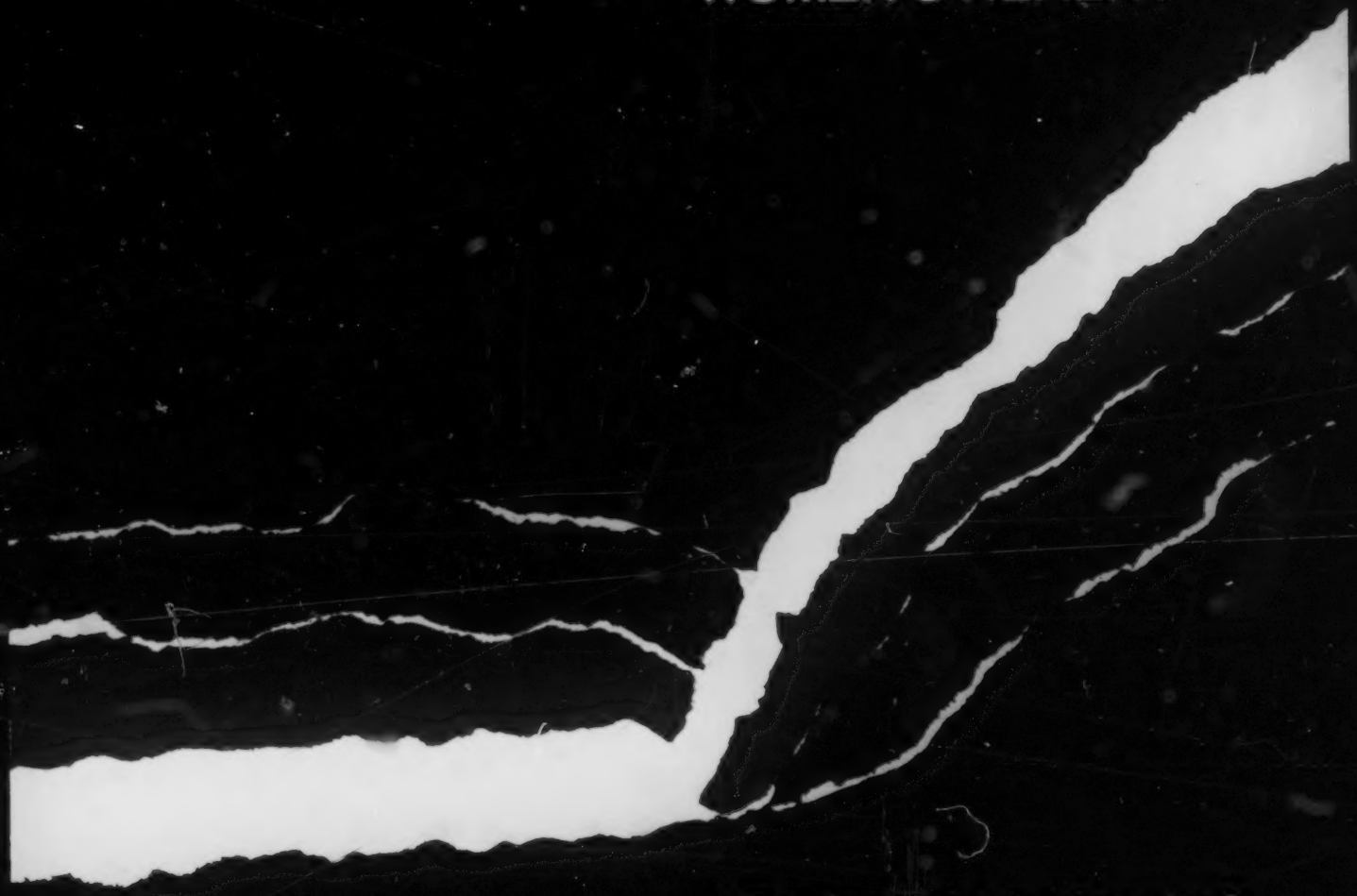
# ABORTION AND WOMEN'S HEALTH



A Turning Point for America?

The Alan Guttmacher Institute

# ABORTION AND WOMEN'S HEALTH

## A Turning Point for America?

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With an Afterword by Jeannie I. Rosoff

Research compiled and analyzed by Stanley K. Henshaw, Laura Duberstein and Rachel Benson Gold

The Alan Guttmacher Institute

New York and Washington, D.C.

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## Preface

Since the end of World War II, most of the world's developed countries have liberalized their abortion laws and now permit abortions to be performed legally under a wide variety of circumstances.[1] The United States is no exception. Abortion has been legal nationally since 1973, when the Supreme Court ruled that a woman's constitutional right to privacy includes her right to decide, in consultation with her physician, whether or not to terminate her pregnancy.

Abortion is now an extremely safe procedure. Deaths from illegal abortion have all but disappeared in the United States, and deaths from legal abortion are rare. Since 1973, as abortion services have become increasingly available in all states, American women have been able to obtain an abortion earlier and earlier in pregnancy, when the procedure is safest. Complications from legal abortion, either physical or emotional, are now very infrequent occurrences. In addition, legal abortion has been associated with important declines in U.S. maternal and infant mortality rates.

These significant individual and public health benefits of the availability of legal abortion are now threatened.

## A Brief History

Abortion is not a new phenomenon in the United States. Abortions early in pregnancy were permitted by traditional common law until the middle of the 19th century. At that time, states concerned about women's health and the professionalization of medical care began to pass laws prohibiting abortion in all but the most extreme circumstances. By 1900, abortion was illegal throughout the United States.[2] Heeding the calls of major national medical, legal, religious and social welfare organizations, and responding to a rising tide of public opinion, state legislatures began to reconsider the issue in the late 1960s. Between 1967 and 1973, when the Supreme Court issued its landmark decisions in *Roe* v. *Wade* and *Doe* v. *Bolton*, 17 states* reformed their antiabortion laws or repealed them outright, and similar legislation was at least introduced in almost every state in the nation.[3] In 1972, nearly 600,000 legal abortions were performed across the country.[4]

### A Patchwork

In the years immediately preceding the 1973 Supreme Court decisions, abortion policy in the United States was a patchwork of differing state abortion laws. But even the antiabortion laws that existed did not prevent women from obtaining an abortion; instead, they created a two-tiered system in which a woman's ability to obtain an abortion depended largely on her place of residence and her financial resources.

Affluent women sometimes could obtain an abortion from a private physician who was willing to certify a medical indication for an abortion for his or her regular patients. Alternatively, a woman who could afford the costs could travel to another state or another country where abortion was legal.† In the two and a half years preceding *Roe* v. *Wade*, nearly 350,000 women left their own state to obtain a legal abortion in New York, one of the few states where abortion was legal and available to nonresidents.[5] Many of these women traveled long distances. From Florida, 19,000 women went to New York for an abortion, as did 30,000 or more women each from Michigan, Ohio and Illinois (Figure 1).[6] This travel often involved costs to the woman above and beyond the monetary ones of the procedure, travel and lodging. One of the

*Four of these 17 states—Alaska, Hawaii, New York and Washington—repealed their antiabortion statutes. The remaining 13 states—Colorado, Arkansas, California, Delaware, Florida, Georgia, Kansas, Maryland, New Mexico, North Carolina, Oregon, South Carolina and Virginia—reformed their laws to permit abortion only when the woman's life was endangered, when her physical or mental health was threatened, if the pregnancy was the result of rape or incest or if the fetus had been diagnosed as having a severe physical or mental defect. Many of these states interpreted their laws narrowly, leading to abortion being generally unavailable in most jurisdictions.

†In 1972, 44 percent of all abortions in the United States were obtained outside a woman's state of residence; by 1976, just three years after *Roe* v. *Wade*, only 10 percent of women having an abortion had to travel out-of-state for the procedure.

**Figure 1. Before *Roe* v. *Wade*, thousands of American women traveled to New York to obtain a legal abortion.**

**July 1, 1970–December 31, 1972**

**Total: 334,237**

Note: Data on Alaska and Hawaii are excluded from the map but are included in the national total.

(See page 73 for state totals.)

**Sources: July–Dec. 1970—** New York State Department of Health, *Report of Selected Characteristics on Induced Abortions Recorded in New York State*, Albany, Apr. 1971, Table 5. **Jan.–Dec. 1971—** ——, *Report of Selected Characteristics on Induced Abortions Recorded in New York State*, Albany, Aug. 1974, Table 6. **Jan.–Dec. 1972—** ——, *Report of Selected Characteristics on Induced Abortions Recorded in New York State*, Albany, Jan. 1974, Table 6. New York City Department of Health, "New York City Health Department Study Indicates Nearly Half a Million Abortions to City Residents Since 1970 Legalization," press release, New York, Aug. 4, 1977.

most serious consequences was the resulting delay in having the procedure performed. No more than 10 percent of New York City residents having an abortion in that city in 1972 did so after the first 12 weeks of pregnancy. In contrast, fully 23 percent of women who traveled to New York City for an abortion from states not contiguous to New York had their abortion after 12 weeks of pregnancy.[7]*

Less affluent women often turned to illegal, clandestine procedures. Estimates of the annual number of illegal abortions in the 1950s and 1960s ranged from 200,000 to 1.2 million.[8] One analysis, extrapolating from data obtained in North Carolina, concluded that as early as 1955, 699,000 illegal or self-induced abortions occurred nationwide and that 829,000 took place in 1967, when abortion was still illegal nationwide.[9] Eight percent of low-income women surveyed in New York City in the 1960s said they had attempted to terminate at least one pregnancy by illegal abortion; 38 percent said that a friend, relative or acquaintance had attempted to obtain an abortion. Of the low-income women in that study who said that they themselves had had an abortion, 77 percent said they had attempted a self-induced procedure.[10]

Across the country, many of these women died. In 1930, abortion was listed as the official cause of death for almost 2,700 American women, 18 percent of all maternal deaths recorded in that year. By 1940, the death toll had declined to just under 1,700 women. The number of reported abortion-related deaths fell to 316 in 1950, most likely because of the introduction of antibiotics in the 1940s, which permitted more effective treatment of the infections that frequently developed after illegal abortion.[11] By 1965, the number of deaths due to illegal abortion had fallen to 193, but illegal abortion still accounted for 17 percent of all deaths attributed to pregnancy and childbirth in that year.[12]† Because abortion was illegal during those years, the actual number of deaths due to abortion was probably much greater than that officially reported.

Minority women and their families had a disproportionate share of health complications resulting from illegal abortion. From 1972 to 1974, the mortality rate‡ from illegal abortion for women who were not white was 12 times the rate for white women.[13] More than two-thirds of the women who died from illegal abortion from 1972 to 1974 were black or from other minority groups.

Before the legalization of

*Pregnancy generally is measured in weeks from the start of a woman's last menstrual period. Thus, a woman is considered to be 12 weeks pregnant when 12 weeks have passed since her last menstrual period.

†To distribute deaths attributed to "spontaneous or unspecified" abortions, it was assumed that the ratio of spontaneous abortion deaths to pregnancy and childbearing deaths (excluding abortion and ectopic pregnancy) was the same as during the years 1968–1972, and the remaining "unspecified" deaths were apportioned proportionately to illegal and legal abortion deaths.

‡The mortality rate in this instance was computed as deaths per one million women 15–44.

abortion, complications from illegal abortion were a major cause of hospital admission. In 1962 alone, nearly 1,600 women were admitted to Harlem Hospital Center in New York City because fragments of fetal material were left in the uterus during an illegal abortion (this is known as an incomplete abortion).[14] New York City municipal hospitals reported 23 admissions for incomplete abortion for every 100 deliveries performed in 1969; by 1971, the year after the state repealed its antiabortion law, the number of admissions for incomplete abortion fell to 13 per 100 births.[15] After California liberalized its abortion law in 1967, the number of admissions for infection resulting from illegal abortion (known as septic abortion) at Los Angeles County/University of Southern California Medical Center fell by almost 75 percent.[16]

## A Constitutional Right

The Supreme Court had been setting the stage for *Roe* v. *Wade* for several decades, beginning with decisions in the 1920s rejecting state laws that allowed for the compulsory sterilization of certain individuals.[17] From the 1960s onward, the Court considered decisions to limit childbearing as part of a fundamental constitutional right to privacy. In *Griswold* v. *Connecticut* in 1965, the Court recognized the right of married couples to practice birth control without interference from the government and held that statutes interfering with this right

**Figure 2. *Roe* v. *Wade* established a framework within which states may regulate abortion according to the stage of gestation.**

"The Court has recognized that a right of personal privacy . . . does exist under the Constitution. . . . This right . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. . . . We, therefore, conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation."

"For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."

"For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health."

"For the stage subsequent to viability, the State, in promoting its interest in the potentiality of human life, may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."

**Source:** Roe v. Wade, 410 U.S. 113 (1973).

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violated couples' marital privacy.[18] In 1972, the Court extended this right, in *Eisenstadt* v. *Baird*, to unmarried persons and defined a constitutional right to privacy broad enough to include "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[19]

Against this background, the Court issued its abortion decisions on January 22, 1973. In *Roe* v. *Wade* and *Doe* v. *Bolton*, the Court held that a woman's right to choose whether to obtain an abortion, like her right to use birth control without governmental interference, is constitutionally protected as part of a woman's fundamental right to privacy.[20]

The Court stressed, however, that a woman's right to choose abortion is not absolute and that it must be balanced against the state's legitimate interest in protecting both the health of the pregnant woman and the developing human life. Accordingly, in its decision, the Court delineated a framework within which states could regulate abortion (Figure 2). It essentially prohibited states from interfering with a woman's right to choose whether to obtain an abortion during the first trimester of pregnancy—roughly the first 12–14 weeks. From that point on in the pregnancy, according to the Court, states could enact laws necessary to protect the health of the pregnant woman. However, only when the fetus reached the point of viability (that is, the ability to survive outside the woman's body) at roughly the end of the second trimester, did the state's interest in potential human life become sufficiently compelling to justify restricting or prohibiting abortions entirely, except when necessary to protect the life or health of the woman.

For nearly two decades, *Roe* v. *Wade* has provided the basis for legal abortion in the United States. Although states have continued to legislate extensively on the issue of abortion, most state attempts to restrict abortion have been found to be inconsistent with *Roe* and have thus been struck down by the courts. These restrictions have included provisions that mandate waiting periods, that give a husband veto power over his wife's decision to have an abortion, that require physicians to give women specific information that may not be relevant to her particular medical circumstances (e.g., details of the risks of an abortion at 16 weeks of pregnancy for a woman who is terminating her pregnancy at eight weeks) and that require that all abortions after the first trimester be performed in hospitals even when there is no medical reason for doing so.

The two major types of restrictions that have been upheld are some requirements for the involvement of parents in their minor daughter's abortion decision and restrictions on the use of public funds to provide abortion

services. In *Belotti* v. *Baird* in 1979, the Court allowed states to require that parents consent to their daughter's abortion if the states provide an alternative procedure—usually involving an appearance before a judge—whereby a minor can demonstrate that she is sufficiently mature to decide to have an abortion without parental consent or that it is in her best interests for the abortion to be performed.[21] Twelve states* require minors seeking abortions to either involve their parents or use the so-called judicial bypass procedure before having an abortion; two additional states, Maryland and Utah, require parental notification "if possible" for unemancipated minors but do not have judicial bypass alternatives.[22] In *Harris* v. *McRae*, in 1980, the Court allowed federal and state governments to exclude coverage of abortions from Medicaid, the joint federal-state program that provides medically necessary services to some, but not all, of the poor.[23] All but 13 states† now prohibit Medicaid coverage of abortions in almost all circumstances.[24]‡

In 1989, the Court abruptly changed the direction it had set with *Roe* v. *Wade* nearly two decades earlier. While the Court's previous decisions since *Roe* had voided most state attempts to restrict legal abortion services, the decision in *Webster* v. *Reproductive Health Services* signaled that the Court's thinking had changed, and that it might now approve a wider range of state-imposed abortion restrictions[25] (see below, p. 39). Exactly what restrictions states will adopt, and what restrictions will be approved by the Court, will be decided in the coming months and years by the states, the courts and public opinion.

### Abortion Safety at Risk

In the 17 years since *Roe* v. *Wade*, the question of the health impact of legal abortion has been exten-

*Nine states currently require parental consent: Alabama, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Missouri, North Dakota and Rhode Island. Three states require parental notification: Arkansas, West Virginia and Wyoming.

†Thirteen states—Alaska, California, Connecticut, Hawaii, Maryland, Massachusetts, New York, New Jersey, North Carolina, Oregon, Vermont, Washington and West Virginia—fund all or most medically necessary abortions for indigent women eligible to receive publicly subsidized health care. Minnesota, Pennsylvania, Wisconsin and Wyoming fund abortions in cases of life endangerment, rape or incest; Iowa and Virginia fund abortions in cases of life endangerment, rape, incest and diagnosed severe fetal defect. Colorado funds abortions in cases of life endangerment or fetal defect. The remaining states follow federal guidelines to fund abortions only in cases of life endangerment.

‡Congress has also prohibited the use of federal funds to pay for abortions, except in cases of life endangerment, through other programs that provide health care to Native Americans, military personnel and Peace Corps volunteers, as well as through the health benefit plans offered to federal employees and their dependents. Although Congress passed legislation requiring federal funding of abortions for poor women who become pregnant because of rape or incest and permitting the District of Columbia to use its own funds for medically necessary abortions in 1989, President Bush vetoed both measures. One other federal restriction on abortion involves abortion-related research. Since its enactment in 1970, the Family Planning Services and Population Research Act (Title X of the Public Health Service Act), the basic authority for contraceptive and population-related research, has prohibited the use of family planning funds in programs where abortion is a method of family planning. The National Institutes of Health have interpreted this as a prohibition on abortion-related research and on research on any drugs or devices as abortifacients.

sively examined. The first major study of the issue, released by the Institute of Medicine of the National Academy of Sciences as early as 1975, concluded that "[m]any women will seek to terminate an unwanted pregnancy by abortion whether it is legal or not. . . . Evidence suggests that legislation and practices that permit women to obtain abortions in proper medical surroundings will lead to fewer deatns and a lower rate of medical complications than restrictive legislation and practices. The substantial differences between the mortality and morbidity associated with legal abortion in the first and second trimesters suggest that laws, medical practices, and educational programs should enable and encourage women who have chosen abortion to obtain it in the first three months of pregnancy."[26]

Several years later, in 1987, President Ronald Reagan directed Surgeon General C. Everett Koop to prepare a report on the physical and psychological health effects of abortion. Since Koop, along with President Reagan, was a vocal foe of abortion, activists on both sides of the issue expected his report to support the contention of the antiabortion movement that abortion has severe adverse effects, particularly psychological ones, on women.

After an exhaustive 15-month study, Koop declined to release a report. Instead, he sent a letter to the President saying that existing studies "do not provide conclusive data about the health effects of abortion on women."[27] Although no official report was ever issued, the final draft of the Koop report was released by Representative Ted Weiss (D.-N.Y.), chairman of the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, at hearings on March 16, 1989. At those hearings, Koop summed up the conclusions of his report by acknowledging that, while psychological trauma following an abortion can be devastating to some women, the problem is "minuscule from a public health perspective."[28] Koop further said that valid scientific studies have documented that physical health problems, such as infertility, miscarriage, premature birth and low birth weight, are no more frequent among women who have had an abortion than they are among the general population of women.

The following report presents a comprehensive review of the research on the physical and psychological impact of legal abortion in the United States and the implications for the health of American women of possible restrictions on abortion.

## Abortion in America

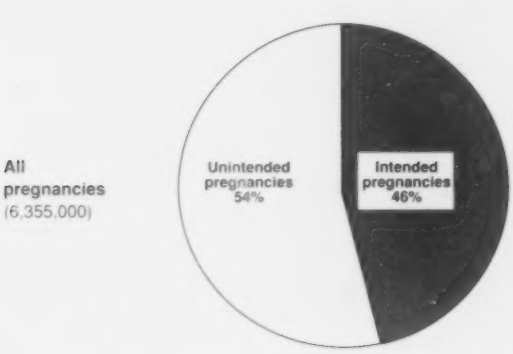
### Who Has an Abortion And Why?

Each year, more than six million American women—11 percent of all women of reproductive age—become pregnant; more than half of these pregnancies are unintended (Figure 3).[29] Of the 3.4 million women who become pregnant unintentionally in the United States each year, approximately 1.4 million carry their pregnancy to term and give birth; 400,000 have a miscarriage; and 1.6 million terminate their unintended pregnancy through abortion.[30] Two-thirds of women have at least one unintended pregnancy by the time they reach menopause.[31]

That is not surprising, in that a woman is fertile for nearly half of her life. The average girl is capable of becoming pregnant for several years before she becomes sexually active and then is sexually active for several years before becoming pregnant and giving birth for the first time. A woman is then able to become pregnant for many more years after she has had all the children she wants to have, unless she is protected by surgical sterilization. In short, for 90 percent of her reproductive life, the average woman is trying to either postpone giving birth or avoid having more births; for only 10 percent of her reproductive life is she actually pregnant or attempting to become pregnant (Figure 4).[32]

Ninety-two percent of women

**Figure 3. More than half of pregnancies each year in the United States are unintended . . .**




**. . . and almost half of those unintended pregnancies end in abortion.**

Note: These data are estimates.

**Sources: Number of births**—National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1987," *Monthly Vital Statistics Report*, Vol. 38, No. 3, Supplement, June 29, 1989. **Percentage of unintended births**—J. D. Forrest, "Unintended Pregnancy Among American Women," *Family Planning Perspectives*, **19**:76, 1987. **Number of abortions**—S. K. Henshaw, J. D. Forrest and J. Van Vort, "Abortion Services in the United States, 1984 and 1985," *Family Planning Perspectives*, **19**:63, 1987. **Number of miscarriages**—estimated as equal to 10 percent of abortions plus 20 percent of births, according to a model developed by C. Tietze and J. Bongaarts, The Population Council.

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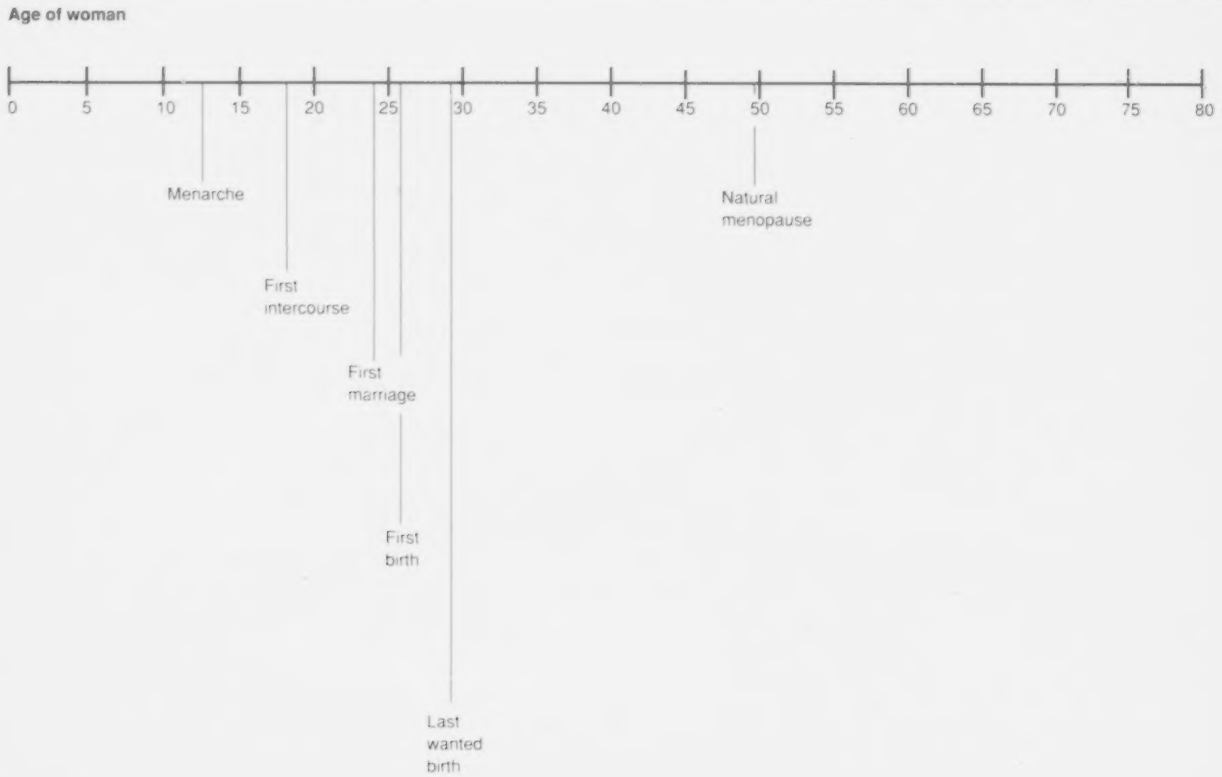
**Figure 4. For over a third of her life, the average American woman is trying to avoid pregnancy.**




(See page 73 for data points.)

**Source:** J. D. Forrest, "Contraceptive Needs Through Stages of Women's Reproductive Lives," *Contemporary Ob/Gyn*, **12**:12, 1988.

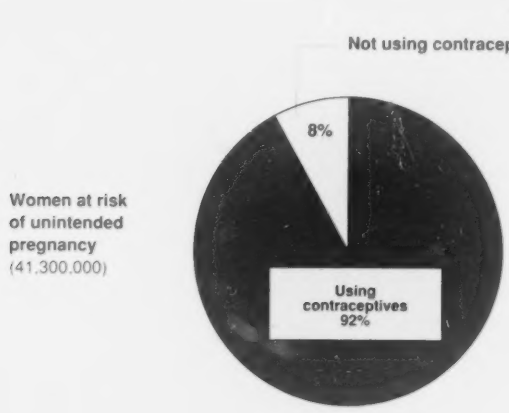


who are at risk of unintentionally becoming pregnant practice some form of contraception. Because contraceptives and their users are not perfect, the 38 million sexually active women and their partners using contraceptives account for 1.5 million unintended pregnancies, 43 percent of all unintended pregnancies in the United States (Figure 5). The 3.3 million women not practicing contraception, who make up eight percent of women at risk of unintended pregnancy,* account for 1.9 million unintended pregnancies, 57 percent of the national total.[33]

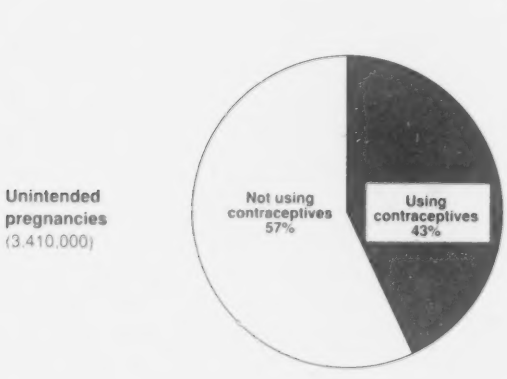
Half of all women having an abortion reported in a 1987 survey that they had used some contraceptive method in the

*Women are said to be at risk of unintended pregnancy if they are sexually active, are physically able to become pregnant, and do not want to have a baby at the time.

**Figure 5. Although almost all women at risk of unintended pregnancy use contraceptives . . .**




**. . . the small proportion who do *not* account for more than half of all unintended pregnancies.**




Note: These data are estimates.

**Sources: Number and percentage of couples not using contraceptives**—J. D. Forrest and R. R. Fordyce, "U.S. Women's Contraceptive Attitudes and Practice: How Have They Changed in the 1980s?" *Family Planning Perspectives*, **20**:112, 1988. **Number of births from unintended pregnancies by contraceptive use**—J. D. Forrest, unpublished tabulations of data from the 1982 National Survey of Family Growth. **Abortions by prior contraceptive use**—S. K. Henshaw and J. Silverman, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," *Family Planning Perspectives*, **20**:158, 1988.

month they became pregnant. Of the women who did not use contraceptives that month, most said that they had used contraceptives in the past. Only nine percent of abortion patients said they had never practiced contraception to prevent pregnancy.[34]

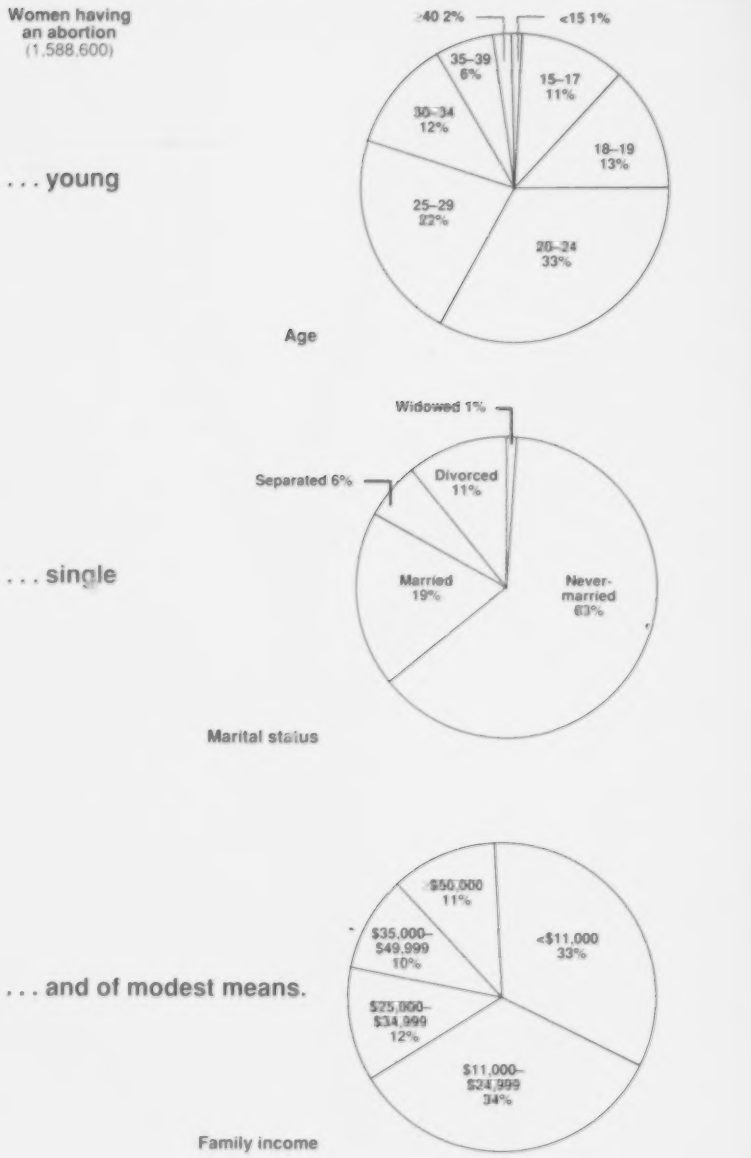
Older abortion patients are more likely to have practiced some form of contraception than are younger patients who have been sexually active for a shorter time. Thirty-nine percent of abortion patients 17 years or younger said they had used some form of contraception in the month they had become pregnant, compared with 52 percent of patients 20–29 years old. Twenty-seven percent of patients 17 or younger said they had never practiced contraception, compared with only six percent of women in their twenties.[35]

■ CHARACTERISTICS. Although women who have an abortion come from all segments of American society, most are young, not married and not yet economically established.

*Age.* Most abortion patients are young (Figure 6). More than half of all women obtaining an abortion are under age 25, with 25 percent under age 20. One percent of patients are younger than 15; six percent are 35–39, and two percent are 40 or older.[36]

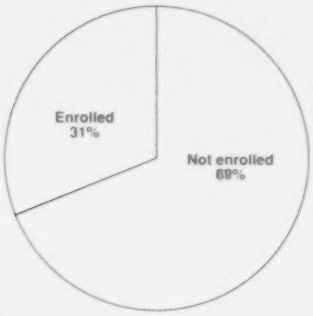
*Marital status.* More than six in 10 women having an abortion are not married[37] (Figure 6). Women

**Figure 6. Who has an abortion? Women having an abortion are predominantly . . .**



## And many are . . .

. . . in school




School enrollment

. . . or employed.

Employment status

**Women having an abortion**
(1,588,600)

Note: The total number of women having an abortion is for 1985. The distributions are for 1987.

**Sources:** S. K. Henshaw and J. Silverman, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," *Family Planning Perspectives*, **20**:158, 1988. **Family income**—Ibid.; and S. K. Henshaw, unpublished tabulations of data from a 1987 nationwide Alan Guttmacher Institute survey of 9,480 abortion patients.

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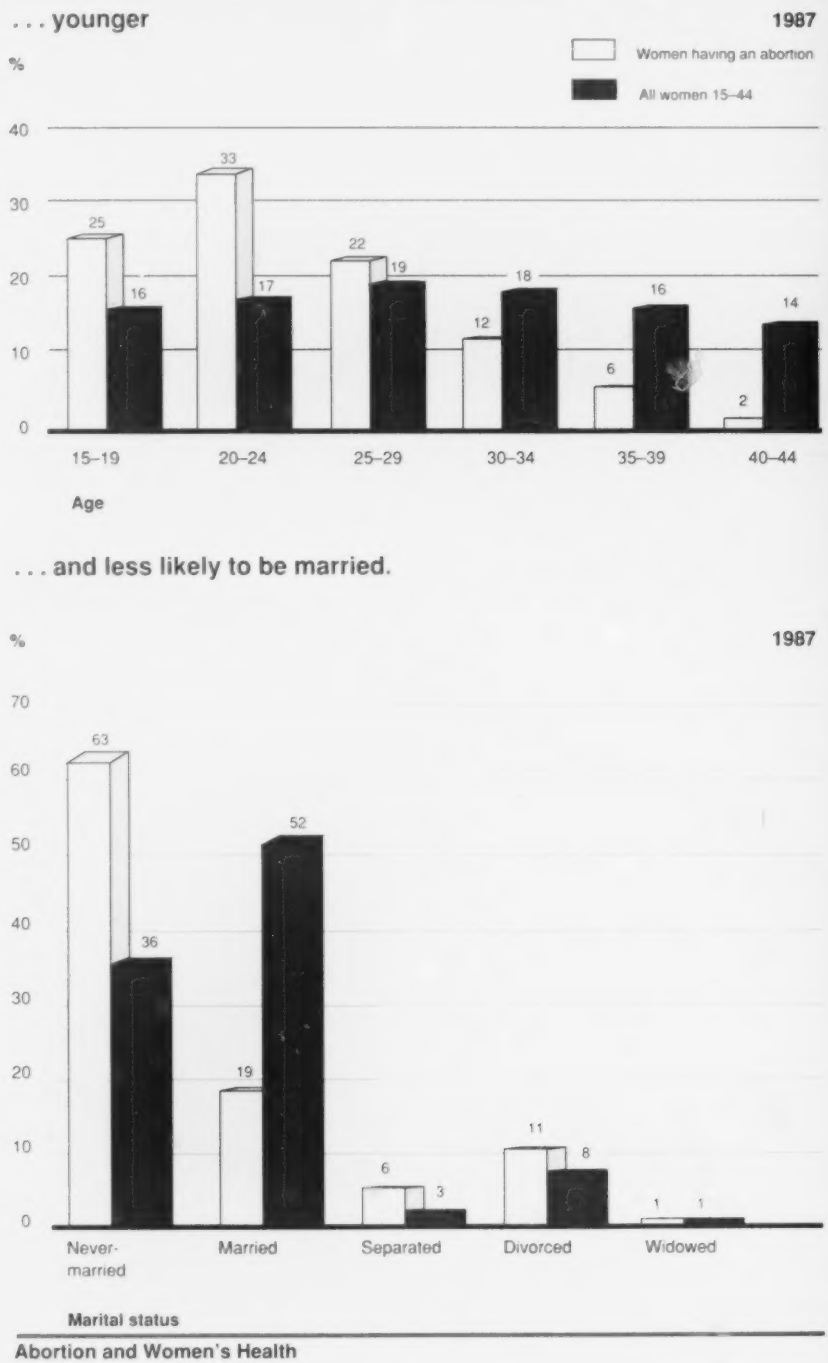
who have never been married are five times more likely to have an abortion than are married women, because they are much more likely to have unintended pregnancies and to choose abortion when they do become pregnant.[38] Women who are separated from their husbands are twice as likely as all women to have an abortion, while married women who live with their husbands are much less likely than all women to do so (Figure 7).[39]

*Income.* Although abortion patients come from families of all income levels, women with a family income of under $11,000 are nearly four times as likely to have an abortion as women with a family income of over $25,000. Nearly one-quarter of all abortion patients, compared with nine percent of all women, are poor enough to be covered by Medicaid.[40] Medicaid recipients are three times more likely than women who are not covered by Medicaid to have an abortion, even though Medicaid will not pay for abortions in most states.[41]

*Education and employment.* Thirty-one percent of women having an abortion attend school (Figure 6). Women who are in school are almost twice as likely as those who are not to have an abortion. Over two-thirds of abortion patients are employed. Women who are employed are slightly more likely to have an abortion than are women who are unemployed.[42]

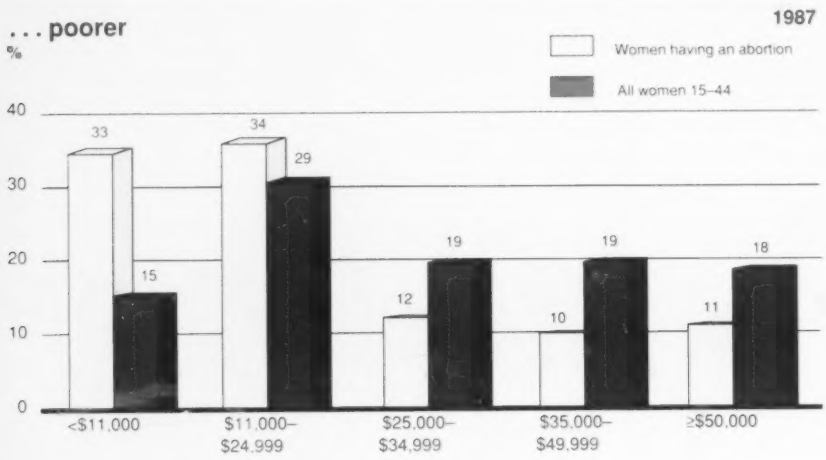
**Figure 7. How do women having an abortion compare with all American women of reproductive age? They are . . .**



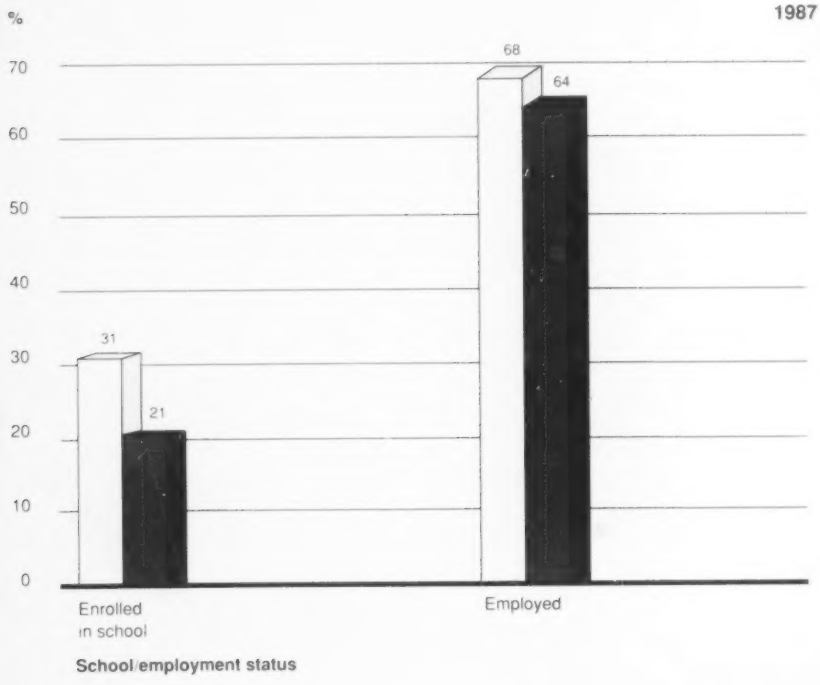

**Abortion and Women's Health**

## They are also . . .

### . . . poorer




### . . . and more likely than all women to be in school and to be employed.




(See next page for sources.)

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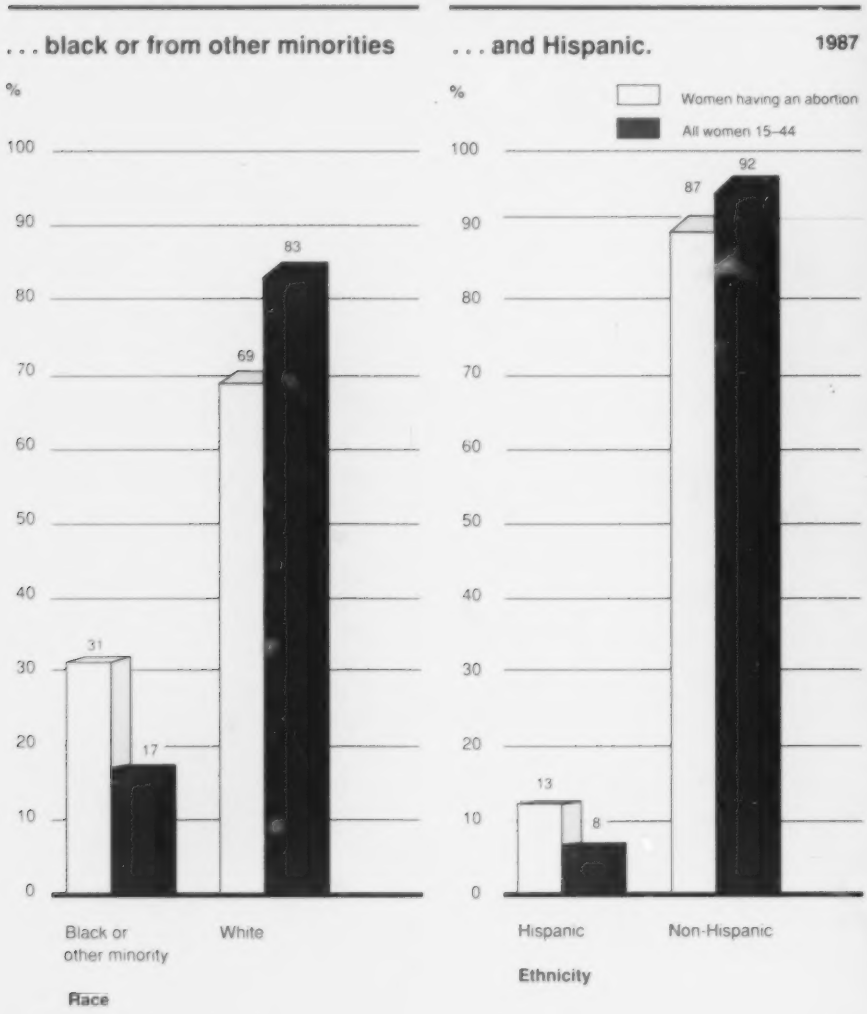
**Figure 7 (continued). Compared with all women of reproductive age, women having an abortion are disproportionately . . .**




Note: All data are for 1987 except school enrollment for all women (1986) and family income for all women (1985).

**Sources:** S. K. Henshaw and J. Silverman, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," *Family Planning Perspectives*, **20**:158, 1988. **Family income**—Ibid.; and S. K. Henshaw, unpublished tabulations from U.S. Bureau of the Census, unpublished data from the Current Population Survey, Table PF1; and U.S. Bureau of the Census, "Money Income of Households, Families and Persons in the U.S.: 1985," *Current Population Reports*, Series P–60, No. 156, 1987, Table 18.

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*Race and ethnicity.* Nearly 70 percent of all women having an abortion are white. However, because women who are members of a minority group are more likely to have an unintended pregnancy, minority women are more than twice as likely as white women to have an abortion. Similarly, although Hispanic women account for only 13 percent of all abortion patients, they are more likely to have an abortion than are women who are not Hispanic or women overall.[43]

*Religion.* Protestant and Jewish women are less likely to have an abortion than are all women. The abortion rate (abortions per 1,000 women 15–44) among Catholics, however, is close to the national average, and is a third higher than that among Protestant women.[44] Women who describe themselves as "born again" or Evangelical are half as likely as women overall to have an abortion. Catholics who are not Evangelical are 15 percent more likely than Protestants who are not Evangelical to have an abortion.[45*]

■ REASONS. The decision to have an abortion is a complex one for most women. Ninety-three percent of abortion patients say that more than one factor influenced their decision; on average, patients cite four different reasons.

*The large number of black women who are Protestant and the large number of Hispanic women who are Catholic influence the abortion rates of the religious groups. However, even when only white women who are not Hispanic are considered, Catholics still are 38 percent more likely to have an abortion than are Protestants.

The reasons given most frequently reflect the fact that most abortion patients are young, have never been married and feel unprepared to begin a family. Three in four women having an abortion say that they are not ready for how a baby could change their life (Figure 8). These women most frequently say that having a baby would interfere with work, school or other responsibilities they must assume or have undertaken. Two-thirds of all abortion patients say they cannot afford a baby at this point in their life; half say they either do not want to be a single parent or are having problems in their relationship with their husband or partner.[46]

As a further reflection of the young age of many abortion patients, as many as three in 10 women having an abortion say that they are not ready for the responsibility of a child, are not mature enough to be a parent or are too young to have a child. Eight in 10 abortion patients under age 18 say that they are not mature enough for parenthood; four in 10 under age 18 say they do not want others to know that they have had sex or are pregnant.[47]

Thirty percent of women who have an abortion do not intend to have more children. Fifty percent of patients over 30 years of age say they decided to have an abortion because they have all the children they want or because their children are grown.[48]

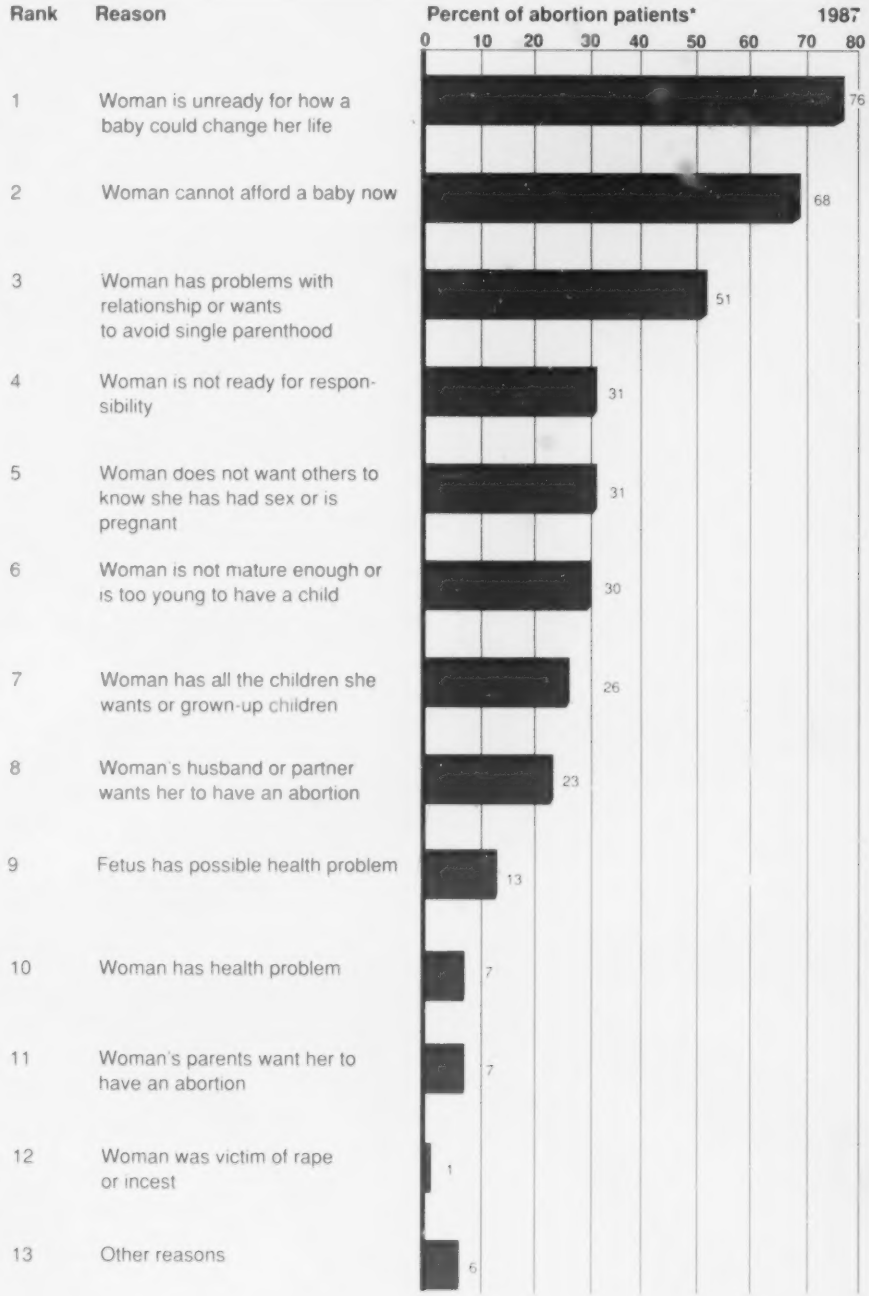
While most abortions take place because the woman did not

intend to become pregnant, some women who did want to become pregnant also choose abortion. Thirteen percent of abortion patients say they made the choice in part because of a possible fetal defect, and seven percent cite a threat to their own health. Some other women probably seek an abortion because of changes in their relationship or economic circumstances since they became pregnant.[49]

## How Many Women Have an Abortion?

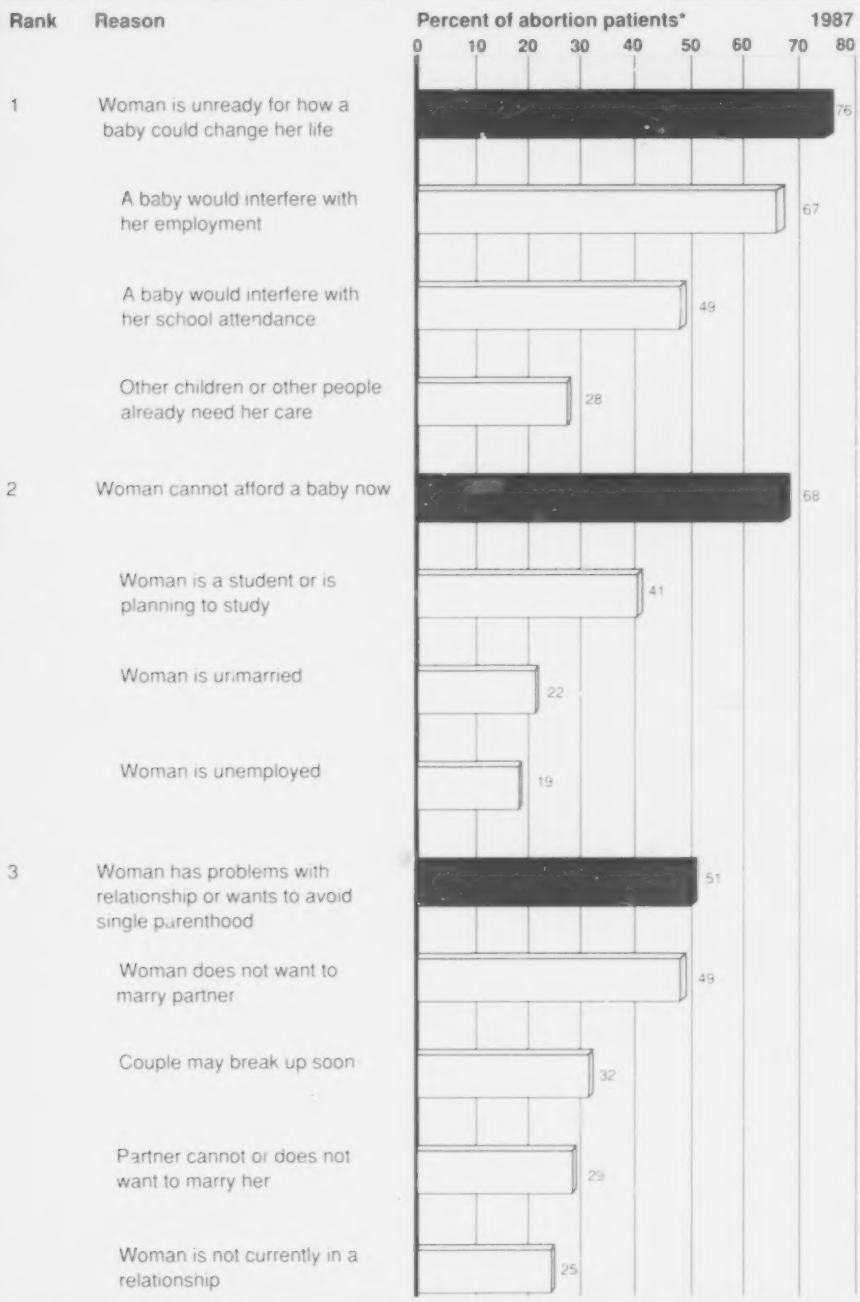
In 1973, the year the Supreme Court legalized abortion nationwide, 745,000 women obtained a legal abortion in the United States.[50] For several reasons, in the years immediately following the decision, this number grew rapidly, to 1.3 million abortions in 1977.[51] First, the number of physicians trained and experienced in the procedure increased, and a nationwide network of outpatient abortion clinics developed that enabled women who would previously have had an illegal abortion, or would not have been able to obtain one at all, to do so legally in a medical facility. In addition, the number of pregnant women who were either unmarried or in an unstable relationship rose as a result of increasing sexual activity among unmarried women and teenagers, increasing proportions of women who were separated or divorced and rising age at marriage. Finally, wide publicity questioning the safety of oral

**Figure 8. Almost all women give multiple reasons for their decision to have an abortion . . .**




Abortion and Women's Health

**. . . and responsibilities, economic circumstances and unstable relationships are the main reasons given.**




*Most women gave multiple reasons.

**Source:** A. Torres and J. D. Forrest, "Why Do Women Have Abortions?" *Family Planning Perspectives*, **20**:169, 1988.

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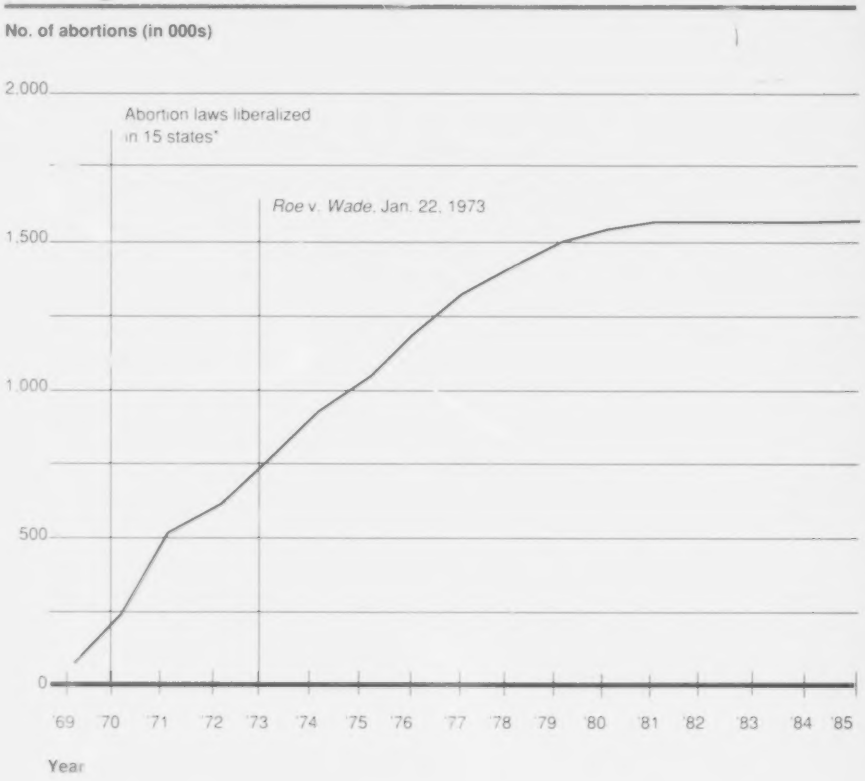
contraceptives, vasectomy and IUDs—in no small measure due to widespread reports of the serious problems resulting from the Dalkon Shield—led some people to switch from these methods to contraceptives more likely to fail and more difficult to use, resulting in an increase in unintended pregnancies. Since 1980, however, the annual number of abortions has leveled off at approximately 1.6 million (Figure 9).[52]

Similarly, the abortion rate—the number of legal abortions per 1,000 women of reproductive age—rose steadily in the years immediately following the Supreme Court decisions, from 16 in 1973 to 26 in 1977, but has remained relatively level since 1978. Since then, 28 or 29 abortions per 1,000 women aged 15–44 have occurred each year.[53]

Approximately 30 percent of pregnancies (excluding those ending in miscarriage) in the United States end in abortion.[54] By 1989, about 16 million American women had had a legal abortion.[55] If current abortion rates continue, nearly half of all women of reproductive age will have had an abortion by the time they reach age 45.[56]

**Figure 9. The annual number of legal abortions has remained relatively stable in the last several years, after rising rapidly in the first few years following *Roe* v. *Wade*.**




*By the end of 1970, four states had repealed their antiabortion laws and 11 states had reformed them.

(See page 73 for data points.)

**Sources: 1969–1972**—Center for Disease Control, *Abortion Surveillance, Annual Summary, 1973*, Atlanta, 1973. **1973–1985**—S. K. Henshaw, J. D. Forrest and J. Van Vort, "Abortion Services in the United States, 1984 and 1985," *Family Planning Perspectives*, **19**:63, 1987.



## How and When Are Abortions Performed?

Most abortions in the United States today take place early in pregnancy.[57]* More than half of

*A full-term pregnancy lasts about 40 weeks. Pregnancy is divided into three trimesters, each approximately 12–14 weeks long.

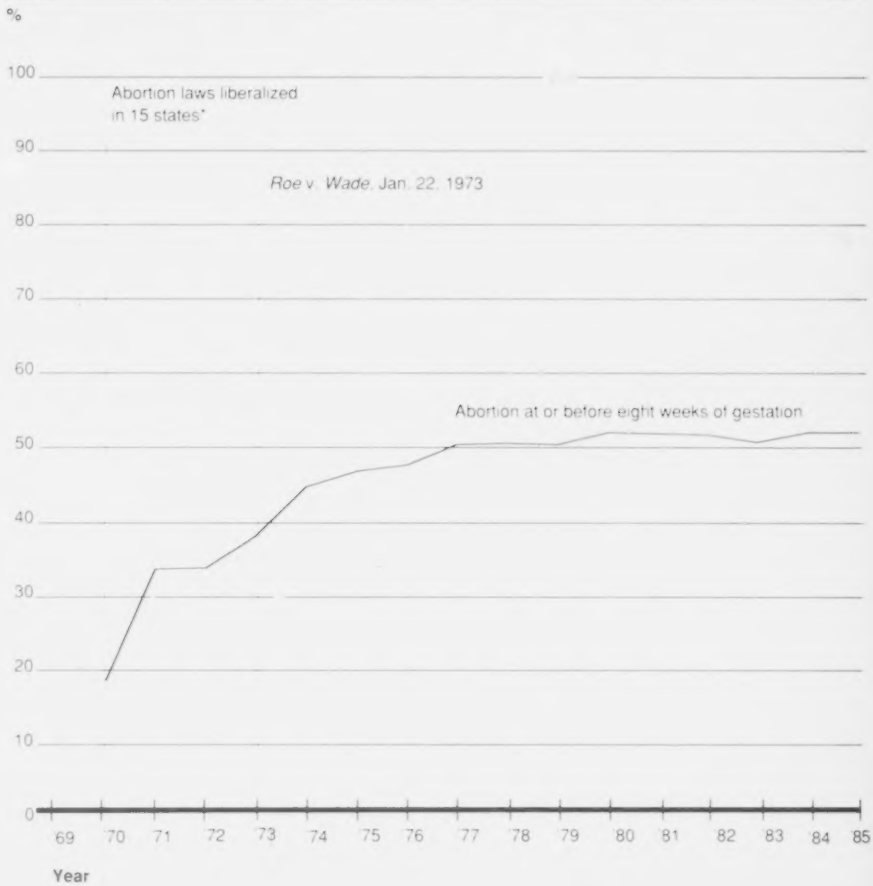
all abortions now occur to women who are no more than eight weeks pregnant. Ninety-one percent of all abortions are performed during the first 12 weeks of pregnancy.[58] Just over 96 percent take place during the first 15 weeks of pregnancy. Only one-half of one percent take place past 20 weeks, with most of these at 21 or 22 weeks of gestation.[59] Only 100 to 200 abortions (or 0.01 percent of all abortions) are performed each year after 24 weeks of pregnancy.[60]

The proportion of abortions performed during the first eight weeks of pregnancy has increased dramatically since 1973 (Figure 10). In 1970, 20 percent of abortions were performed at or before eight weeks. In 1973, 38 percent of all abortions occurred at or before eight weeks; by 1985, that proportion had risen to 52 percent. In 1985, only four percent of all abortions took place at or beyond 16 weeks of pregnancy, compared with nine percent in 1973.[61]

Prior to the introduction of the vacuum aspiration method into the United States in the late 1960s, most early abortions were performed using dilatation and curettage (D&C), a procedure in which the physician scrapes the uterus with a spoon-like instrument. D&C is rarely used in the United States today, and virtually all first-trimester abortions are performed using the safer and less painful vacuum aspiration method.[62]

To perform a first-trimester vacuum aspiration abortion (for

**Figure 10. Since *Roe* v. *Wade*, more women have been having their abortion early in pregnancy.**




*By the end of 1970, four states had repealed their antiabortion laws and 11 states had reformed them.

(See page 73 for data points.)

**Sources: 1970–1972**—Center for Disease Control (CDC), *Abortion Surveillance, Annual Summary, 1970*, Atlanta, 1970; ——, *Abortion Surveillance, Annual Summary, 1971*, Atlanta, 1971; ——, *Abortion Surveillance, Annual Summary, 1972*, Atlanta, 1972. **1973–1985**—S. K. Henshaw and J. Van Vort, eds., *Abortion Services in the United States, Each State and Metropolitan Area, 1984–1985*, The Alan Guttmacher Institute (AGI), New York, 1988, updated for 1985 from CDC and AGI data.

example, at 11 weeks of pregnancy, when the fetus is approximately two inches long and weighs approximately one-half of an ounce), a physician first dilates, or widens, the cervix and then inserts a tube into the uterus; the tube, known as a cannula, is connected to a suction machine that empties the contents of the uterus through the cannula.[63] The physician then examines the tissue that has been removed to ensure that the uterus has been emptied completely. The entire procedure lasts about five minutes and usually requires only local anesthesia, although some patients request that general anesthesia be used.

In the 1970s, physicians in the United States began using dilatation and evacuation (D&E), which is similar to the vacuum aspiration method, for abortions after the first trimester. (Before that time, no method was considered appropriate for abortion early in the second trimester in the United States, and women who were 13 or 14 weeks pregnant were often required to wait several weeks before an abortion could be performed.) D&E is now the most common method of abortion in the second trimester.[64]

A physician performing a D&E must first dilate the patient's cervix. Because the fetus is larger than in the first trimester, the cervix must be dilated more to permit the physician to completely empty the uterus. (At 14 weeks, the fetus weighs approximately four ounces and is five inches long.[65]) This generally is done with the insertion of either a succession of small rods that are graduated in size or an osmotic dilator that absorbs fluid and causes the cervix to dilate. The process of dilating the cervix adequately for a D&E can take as long as several hours, or even overnight. In addition to the suction machine, the physician may also use forceps to ensure that all fetal parts have been removed. Once the cervix is dilated, a D&E usually takes about 10 minutes or less. Ninety-five percent of all abortions in the United States are now performed using either vacuum aspiration or D&E.[66]

For many of the remaining abortions performed late in the second trimester, physicians use medical induction, a procedure in which the physician injects urea or saline solution into the uterus to induce contractions that cause the expulsion of the fetus. Alternatively, physicians administer prostaglandin vaginal suppositories or intramuscular injections to induce labor and fetal expulsion. These contractions are painful and can last several hours.

### Where Are Abortions Performed?

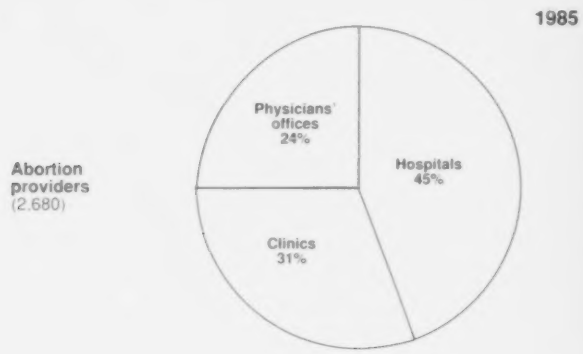
Eighty-seven percent of abortions are performed in physicians' offices or freestanding clinics that may or may not specialize in abortion. Clinics, which represent only 31 percent of the places where abortions are performed, account for 83 percent of all abortions (Figure 11). Only 1,191

hospitals, 21 percent of all general, short-stay hospitals nationwide, offer abortion services. These hospitals, which constitute 45 percent of all abortion providers nationwide, account for only 13 percent of all abortions.[67]

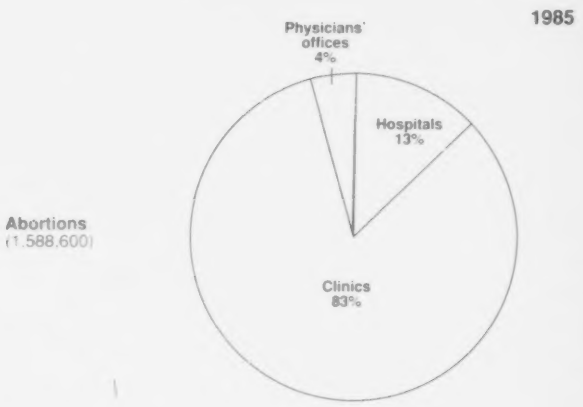
Between 1982 and 1985, the total number of abortion providers decreased by eight percent, from 2,908 to 2,680. In the three years from 1982 to 1985, the number of hospitals reporting abortions fell by 15 percent, from 1,405 to 1,191. The number of public hospitals that perform abortions decreased by 20 percent, while the number of private hospitals decreased by 14 percent during that three-year period. The number of physicians reporting that they performed abortions in their private office decreased by nine percent. In the same years, however, the role of clinics increased; the number of clinics performing abortions increased by six percent.[68]

In 1985, six percent of all abortion patients, 89,000 women, traveled outside their home state to obtain an abortion, most likely because there were no abortion facilities in their area.[69] In addition, more than half a million women, one-third of all women having an abortion, traveled to another county.[70] In 1985, 82 percent of all U.S. counties—in which almost one-third of all women of reproductive age lived—had no abortion provider. Abortion services are less available in rural than in urban areas; nine out of 10 nonmetropolitan counties have no facility that

**Figure 11. Almost half of all abortion facilities in the United States are hospitals . . .**




**. . . but most abortions are performed in clinics.**




**Source:** S. K. Henshaw, J. D. Forrest and J. Van Vort, "Abortion Services in the United States, 1984 and 1985," *Family Planning Perspectives*, **19**:63, 1987.

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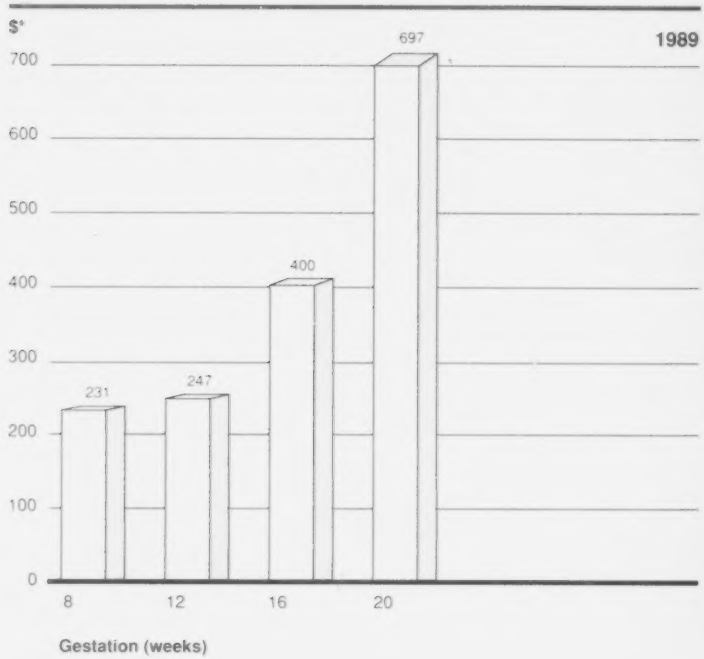
performs abortions. Only 32,000 abortions, two percent of the national total, were performed in nonmetropolitan areas in 1985. In 1982, at least 25 percent of residents of seven states* who had an abortion traveled elsewhere for the procedure.[71]

While virtually all abortion providers perform first-trimester procedures, many do not perform abortions later in pregnancy. Sixty-two percent of clinics, compared with only 13 percent of physicians' offices and 46 percent of hospitals where abortions are done, perform abortions after the first 12 weeks of pregnancy. Only 25 percent of abortion providers perform abortions after 16 weeks of pregnancy.[72]

The average charge for a clinic abortion at eight weeks is $231. Abortions in hospitals are significantly more expensive, because hospitals often have separate charges for the physician's fee, use of the facilities and anesthesia. In 1982, the average charge for a first-trimester abortion performed on an outpatient basis in a hospital was $735, including the physician's fee.[73] The cost of an abortion increases sharply as pregnancy advances and the procedure becomes more complex (Figure 12). Clinics charge an average of $400 for an abortion at 16 weeks and an average of almost $700 for one at 20 weeks of pregnancy.[74]

**Figure 12. The fee for an abortion increases the later in pregnancy the abortion is performed.**




*Average fee for an abortion in a clinic.

**Source:** R. B. Gold, unpublished tabulations of data in *National Abortion Federation Membership Directory*, Washington, D.C., 1989.

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*Indiana, Kentucky, Mississippi, Missouri, South Dakota, West Virginia and Wyoming.

## How Safe Is Abortion in America?

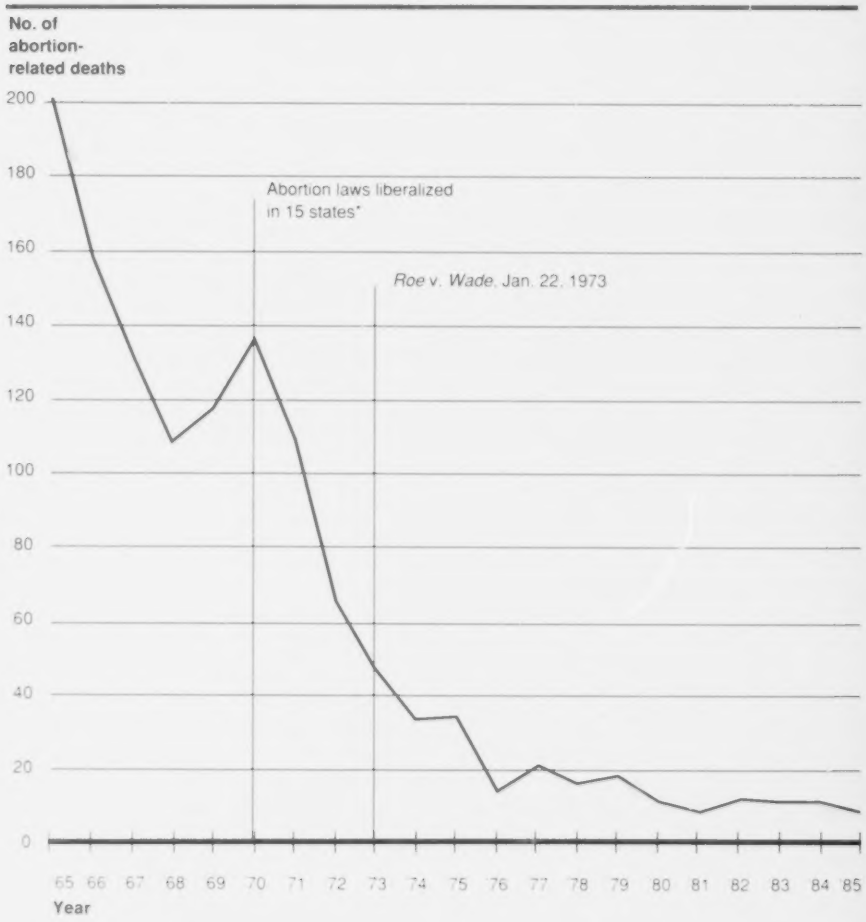
### Mortality

■ RISK OF DEATH FROM ABORTION. The legalization of abortion brought with it a dramatic decrease in the total number of abortion-related deaths (Figure 13). In 1965, when abortion was still illegal nationwide except in cases of life endangerment, a minimum of 193 women died from illegal abortions, and illegal abortion accounted for nearly 17 percent of all deaths due to pregnancy and childbirth in that year.[75]* Fifty-five percent of the abortion-related deaths reported in 1965 were among nonwhite women.[76] Since many deaths from illegal abortion were attributed to other causes on the death certificates or were never reported, the actual number was undoubtedly higher. Even in 1972, when abortion was legal in some states, the Center for Disease Control reported that 41 women died from illegal procedures.[77]† Deaths from illegal abortion fell to 22 in 1973, and to seven in 1974—a more than 80 percent decrease between 1972 and 1974.[78] The nationwide legalization of abortion in 1973 re-

*To distribute deaths attributed to "spontaneous or unspecified" abortions it was assumed that the ratio of spontaneous abortion deaths to pregnancy and childbearing deaths (excluding abortion and ectopic pregnancy) was the same as during the years 1968–1972, and the remaining "unspecified" deaths were apportioned proportionately to illegal and legal abortion deaths.

†This figure includes two deaths for which the legal status of the abortion is unknown.

**Figure 13. Deaths from abortion have declined dramatically since legalization.**




*By the end of 1970, four states had repealed their antiabortion laws and 11 states had reformed them.

Note: Numbers include deaths from both legal and illegal abortion, but exclude those from spontaneous abortion.

(See page 73 for data points.)

**Sources: 1965–1967**—National Center for Health Statistics, *Vital Statistics of the United States, 1965; Vol. II—Mortality, Part A*, U.S. Government Printing Office (GPO), Washington, D.C., 1967; ——, *Vital Statistics of the United States, 1966; Vol. II—Mortality, Part A*, GPO, Washington, D.C., 1968; ——, *Vital Statistics of the United States, 1967; Vol. II—Mortality, Part A*, GPO, Washington, D.C., 1969. To distribute deaths categorized as "spontaneous or unspecified," it was assumed that the ratio of spontaneous abortion deaths to pregnancy and childbearing deaths (excluding abortion and ectopic pregnancy) during 1965–1967 was the same as during the years 1968–1972, and the remaining "unspecified" deaths were induced abortion deaths. **1968–1971**—C. Tietze, "The Effect of Legalization of Abortion on Population Growth and Public Health," in C. Tietze et al., *Abortion 1974–1975: Need and Services in the United States, Each State & Metropolitan Area*, The Alan Guttmacher Institute, New York, 1976, pp. 110–113. **1972–1985**—H. W. Lawson et al., "Abortion Surveillance, United States, 1984–1985," CDC Surveillance Summaries, *Morbidity and Mortality Weekly Report*, Vol. 38, No. SS-2, Sept. 1989, p. 11.

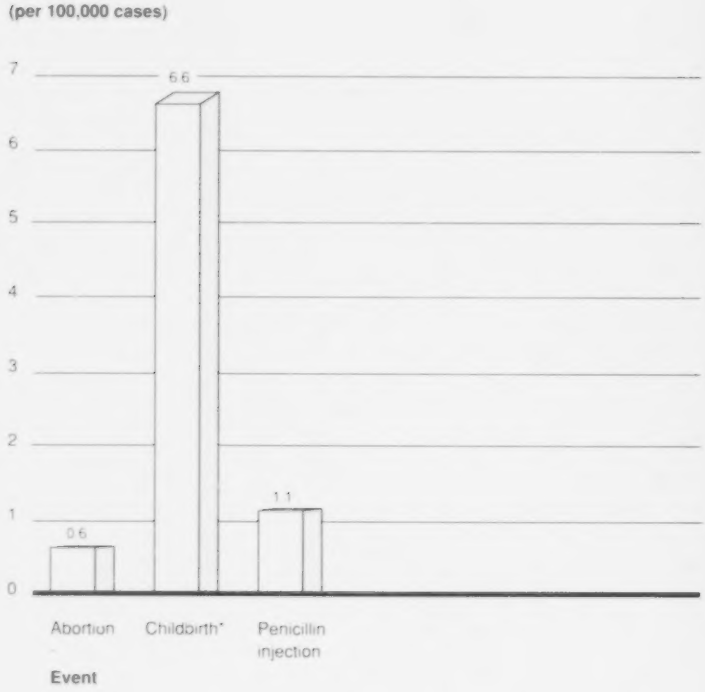
placed almost all illegal procedures with legal abortions by about 1975. However, some women—often those of low income—still resort to illegal procedures.[79]

Although deaths from legal abortion are extremely rare, legal abortion—like any surgical procedure—entails some risk. As the number of legal abortions rose sharply with legalization in the early 1970s, the number of deaths reported as having resulted from legal abortion also increased temporarily. However, as physicians became more experienced and skilled at performing abortions, the risk of dying from an abortion decreased sharply, and the number of deaths dropped even as the number of legal abortions increased. In 1973, the risk of dying from an abortion was 3.4 deaths per 100,000 legal abortions. This rate fell to 1.3 by 1977. By 1985 the risk of dying from a legal abortion had decreased dramatically—to 0.4 deaths per 100,000 legal abortions.[80]

Six of the 1.6 million women having a legal abortion in 1985 are known to have died. One additional woman reportedly died from an illegal abortion that year, for a total of seven abortion-related deaths.[81] In 1985, abortion, both legal and illegal, accounted for, at most, three percent of all reported pregnancy-related deaths.[82]

Although deaths from either abortion or childbirth are rare, for the period 1981–1985, a woman giving birth was 11 times more

**Figure 14. Abortion is safer than childbirth or a shot of penicillin.**




*Excludes death from ectopic pregnancy and abortion.

Note: Data for abortion and childbirth are from 1981–1985. Data for penicillin are from 1954–1969.

**Sources: Deaths from abortion**—H. W. Lawson et al., "Abortion Surveillance, United States, 1984–1985," CDC Surveillance Summaries, *Morbidity and Mortality Weekly Report*, Vol. 38, No. SS-2, Sept. 1989, p. 11. **Number of abortions**—S. K. Henshaw, J. D. Forrest and J. Van Vort, "Abortion Services in the United States, 1984–1985," *Family Planning Perspectives*, **19**:63, 1989. **Deaths from childbirth**—National Center for Health Statistics (NCHS), *Vital Statistics of the United States, 1981, Vol. II—Mortality, Part A*, U.S. Government Printing Office (GPO), Washington, D.C., 1986; ——, *Vital Statistics of the United States, 1983, Vol. II—Mortality*, GPO, Washington, D.C., 1987; ——, *Vital Statistics of the United States, 1984, Vol. II—Mortality, Part A*, GPO, Washington, D.C., 1987; —— *Vital Statistics of the United States, 1985, Vol. II—Mortality*, GPO, Washington, D.C., 1988. **Number of births**—NCHS, "Advance Report of Final Natality Statistics, 1987," *Monthly Vital Statistics Reports*, Vol. 33, No. 3, Supplement, June 29, 1989, Table 1. **Deaths from penicillin**—A. H. Rudolph and B. V. Price, "Penicillin Reactions Among Patients in Venereal Disease Clinics," *Journal of the American Medical Association*, **223**:449, 1973.

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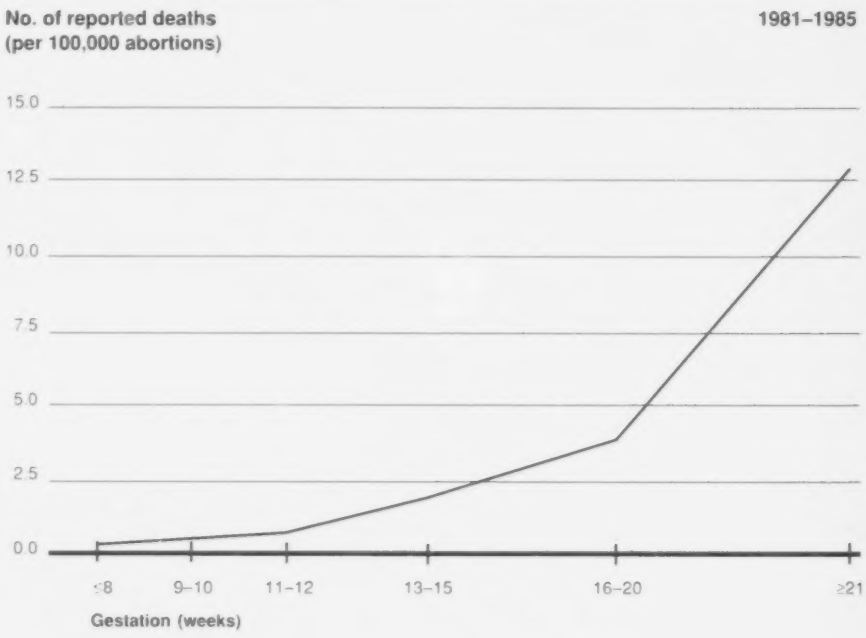
likely to die than was a woman having an abortion; the risk of death from childbirth was 6.6 per 100,000 births, compared with an abortion (legal and illegal) death rate of 0.6 per 100,000 abortion procedures (Figure 14).[83]

To put the risk of death from an abortion into further perspective, between 1954 and 1969 the risk of death from a penicillin injection was 1.1 deaths per 100,000 patients receiving an injection.[84] There are no recent data from the United States on the risk of a penicillin injection, but since that time, the risk of death from abortion has fallen considerably.

■ FACTORS AFFECTING RISK. Despite the improvements in the safety of legal abortion, some abortions carry more risk than others.

*Gestation.* The timing of the abortion is one of the most important factors influencing the risk to the woman (Figure 15). More than half of all abortions are performed at or before eight weeks of pregnancy, when the procedure is the safest. The death rate from an abortion performed at or before eight weeks of pregnancy is 0.2 deaths per 100,000 procedures. The risk rises as gestational age increases. Abortions performed at 11 or 12 weeks of pregnancy are three times more dangerous for the woman than abortions performed at or before eight weeks, although the rate of death from an abortion at 11 or 12 weeks was only 0.6 per 100,000 procedures during 1981–1985.[85]

**Figure 15. The earlier an abortion is performed, the safer it is.**




(See page 73 for data points.)

**Sources: Deaths from legal abortion**—S. K. Henshaw, special tabulations of 1981–1985 data from the Centers for Disease Control (CDC). **Number of abortions by gestational age**—S. K. Henshaw and J. Van Vort, eds., *Abortion Services in the United States, Each State and Metropolitan Area, 1984–1985*, The Alan Guttmacher Institute (AGI), New York, 1988, p. 90, updated for 1985 from CDC and AGI data.

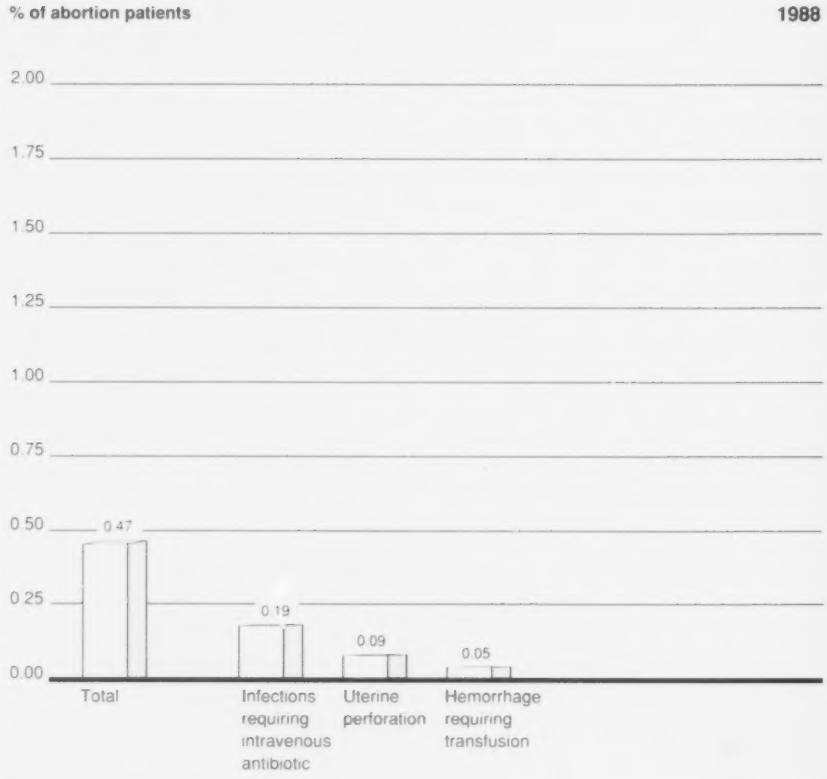
Abortions performed after the first trimester involve greater risk than do first-trimester procedures. The nine percent of abortions performed in the second trimester accounted for 53 percent of all abortion deaths in 1981–1985.[86]

*Method of abortion.* Different abortion methods are associated with different risks, largely because they are used at different stages of pregnancy. Most first-trimester abortions—and therefore most abortions in the United States—are performed using vacuum aspiration, the method that carries the least risk.[87] Techniques used for later abortions, such as medical induction of labor, are associated with higher risks.

*Type of anesthesia.* The type of anesthesia used also affects the risk facing the woman, with general anesthesia being more dangerous than local anesthesia. Women with preexisting conditions, those who wish to be sterilized at the same time they have an abortion and those having a later abortion are more likely to have general anesthesia. However, even when such factors are controlled for, the risk of anesthesia-related death is higher for abortions performed under general anesthesia (0.37 deaths per 100,000 abortions) than for those performed using local anesthesia (0.15 deaths per 100,000 abortions).[88]

*Type of facility.* Clinics are as safe as hospitals for abortions

**Figure 16. Complications following an abortion are rare; fewer than one-half of one percent of patients need hospitalization* . . .**

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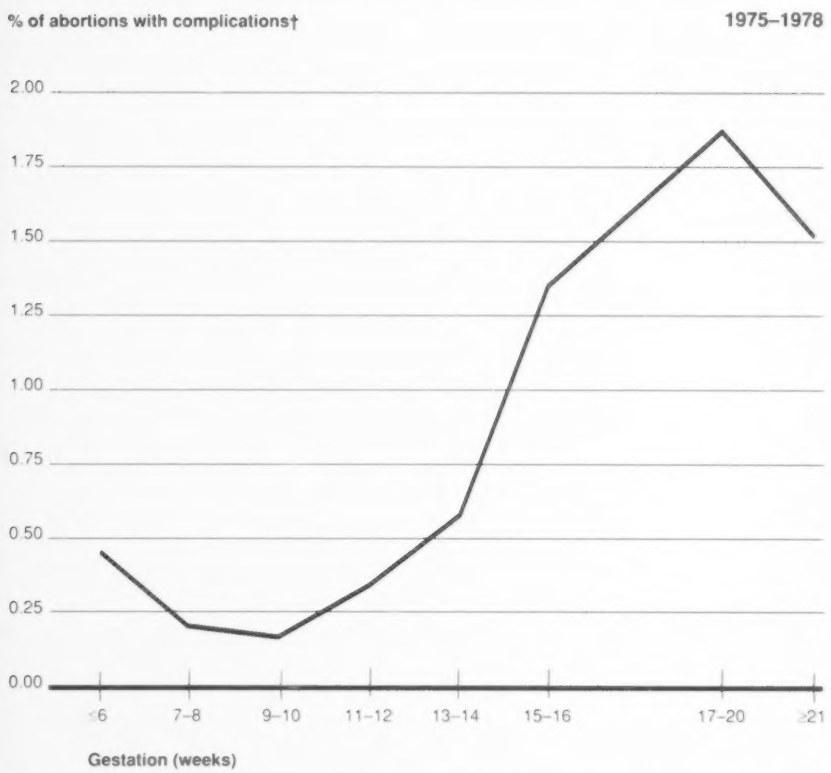
**. . . and the earlier the abortion, the less likely it is that major complications will develop.**




*Patients may have more than one type of complication; rates are based on patients with follow-up only.

†Complications include infection with fever of 104 F for three or more days, hemorrhage requiring blood transfusion and unintended major surgery.

(See page 73 for data points.)

**Sources: Percent hospitalized by complication**—Calculations from data from National Abortion Federation, *Summary of Annual Statistics—1988*, Washington, D.C., Mar. 15, 1989. **Percent of abortions with complications by gestation**—C. Tietze and S. K. Henshaw, *Induced Abortion: A World Review, 1986*, The Alan Guttmacher Institute, New York, 1986.

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performed during the first trimester or early in the second trimester of pregnancy.[89] Similarly, a woman's age does not appear to make a major difference in the risk she faces from an abortion.[90] Perhaps because of differences in income and overall health status in our population, women who are black or are members of other minority groups face a greater risk than do white women.[91]

### Morbidity

Like patients undergoing any surgical procedure or women going through childbirth, women having an abortion are at risk of developing complications. Problems range from minor to potentially life-threatening ones. Major complications from abortion may be defined as those that result in pelvic infection with a fever of 100.4°F for three or more days, major surgery, or hemorrhage requiring blood transfusion.[92]

The risk of developing major complications from legal abortion has decreased greatly since 1970. According to the largest study of abortion-related complications, among patients in 1970–1971—when abortion was legal in some states—the rate of major complications was 0.8 per 100 abortion patients who did not have preexisting conditions or undergo concurrent sterilization; by 1975–1978, when abortion was legal nationwide, the risk had decreased to 0.5 per 100.[93]

Statistics compiled by the National Abortion Federation for 1988 depict the incidence of complications among abortion patients who received follow-up care from the abortion provider. According to these data, uterine perforations occurred in 0.1 out of every 100 patients (Figure 16). Fewer than 0.2 patients per 100 needed intravenous antibiotics for infections arising from abortion. In total, only 0.5 per 100 patients needed hospitalization because of an abortion complication. The most frequent complication arising from an abortion is an incomplete procedure, requiring the abortion to be performed again; this occurs most often because the fetus or embryo is so small it is missed during an early abortion.[94*]

Like the risk of mortality, the risk of developing complications is related to when in pregnancy an abortion occurs, as well as to the method and type of anesthesia used. For abortions performed at seven or eight weeks of pregnancy, the risk of developing major complications is almost 0.2 per 100 (Figure 16). At 13 or 14 weeks, the risk of developing major complications is about 0.6 per 100. At more than 20 weeks, 1.5 per 100 patients develop major complications.[95]

The risk of developing major complications is also related to the abortion method used, although it is not known precisely how much of the increased risk is due to the different methods that are used at different gestational ages and how much of it is associated with gestational age. Vac-

*Statistics report complications among 68,828 patients with follow-up in 1988.

uum aspiration, the most common abortion method and the one used early in gestation, has a major complication rate of 0.2 per 100 procedures.[96] D&E, which is used during the second trimester, has a complication rate of 0.7 per 100 procedures. Labor induction procedures, which are used later in gestation, have the highest risk. As noted above, general anesthesia carries a greater risk than does local anesthesia.[97]

Women giving birth are 100 times more likely than women having abortions to need major abdominal surgery to manage complications.[98] Teenagers do not appear to run a higher risk of developing serious complications of abortion than do older women.[99]

### Psychological Effects

Studies of the reasons for which women obtain an abortion have shown that the decision to terminate a pregnancy is a complex one for most women, and often a difficult one. While many women are relieved after their abortion, some experience short-term feelings of anger, regret, guilt or sadness. For a few, these emotions can become serious psychological problems, although they are not necessarily more serious or frequent than problems caused by an unwanted birth.

Numerous researchers have attempted to determine the extent to which abortion results in psychological problems. Some have claimed that a large number of women having an abortion experience severe emotional problems subsequently as a result of the procedure. Some consider what they term "postabortion syndrome" to be a form of posttraumatic stress disorder, even though abortion does not meet the American Psychiatric Association's definition of trauma.[100] Posttraumatic stress disorder has been seen in up to 15 percent of Vietnam veterans.[101]

After reviewing the more than 250 studies of the psychological outcomes of abortion, former Surgeon General C. Everett Koop concluded in 1989 that most research in this area is marred by such serious methodological flaws that it cannot support the contention that abortion is dangerous to women's mental health.[102]

Four major methodological problems affect this body of research. First, many studies of the psychological effects of abortion violate one of the basic axioms of social science research by failing to use a representative sample as the basis for generalizations to an entire population. In fact, some studies include only women who report postabortion problems. According to a representative of the American Psychological Association, "Generalizing from such samples to the entire population of women undergoing abortions is like estimating the prevalence of strep throat in the entire population of school children by studying the incidence of strep in a pediatrician's office among children who come in complaining of sore throat."[103]

The second major methodological problem affecting many studies concerns the amount of time for which women are followed after they have had an abortion. The longest period of follow-up used in any of the studies examined by the American Psychological Association on the psychological effects of abortion is one year, hardly a sufficient amount of time for long-term problems to surface or for the differences between short-term and long-term problems to be identified.

The third major problem with the existing body of literature is the difficulty in isolating, for research purposes, the extent to which a psychological problem is derived from coping with an unwanted pregnancy or with the abortion procedure itself. According to testimony presented on behalf of the American Psychological Association, "Abortion is inevitably tied up with the experience of having a pregnancy which is problematic. Responses following abortion cannot be attributed to the abortion alone, but have to include the set of events which led up to the abortion as well as the abortion itself."[104]

*Members of the panel were Nancy Adler, Professor, Department of Health Psychology, University of California at San Francisco; Henry P. David, Director, Transnational Family Research Institute, Bethesda, Md.; Nancy Russo, Director, Women's Studies, Arizona State University, Tempe, Ariz.; Brenda Major, Professor of Psychology, State University of New York at Buffalo; Susan Roth, Associate Professor, Department of Psychology, Duke University, Durham, N.C.; and Gail Wyatt, Associate Professor of Medical Psychology, University of California at Los Angeles.

The last major problem is the difficulty that arises in attempting to compare women having an abortion with women whose unwanted pregnancies have other outcomes. According to testimony presented on behalf of the American Public Health Association, "Research on psychological risk factors in the United States is severely handicapped by the absence . . . of control groups of women carrying wanted or unwanted pregnancies to term and keeping the baby or giving it up for adoption."[105]

One recently completed study designed to bypass these methodological pitfalls compared three groups of urban teenagers observed over the course of two years: those who obtained an abortion, those who carried a pregnancy to term and those who had feared they were pregnant but were not. Overall, the young women who chose abortion were no worse off psychologically (either in the short-term or the long-term) than were the other two groups of adolescents.[106]

An expert panel on the psychological aspects of abortion convened by the American Psychological Association* examined the vast body of literature on the psychological impact of abortion and evaluated its methodological soundness.[107] The panel found that although individual studies frequently had major methodological weaknesses, the combined weight of the evidence was clear. The panel unanimously concluded that "legal abortion,

particularly in the first trimester, does not create psychological hazards for most women undergoing the procedure. The studies we reviewed consistently showed the incidence of severe negative reactions to be low and the predominant feelings following abortion to be relief and happiness. Some women report feelings of sadness, regret, anxiety, or guilt, but these tend to be mild."[108]

According to the panel, this conclusion can be considered sound, despite the flaws found in individual studies, because of the consistency of the results of a large number of studies: "The studies reviewed by the panel were done at different times, in different geographical locales, in different clinics and by different researchers. Thus, the consistency of the findings regarding the low incidence of severe negative responses carries substantial weight."[109]

While the data are insufficient to prove that abortion causes psychological problems, both Koop and the American Psychological Association expert panel suggest that some women may be at a greater-than-average risk of experiencing emotional distress following an abortion. According to Koop, "It appears likely that certain factors combine to make deciding to have an abortion and coping with its aftermath more difficult for some women than for others. These factors include strongly held personal values, an ambivalence about abortion, excessive pressure from others, the termination of an originally desired conception, a decision made late into the second trimester, or the lack of partner or family support."[110]

Sixteen million American women have had a legal abortion during the past 17 years, and 1.6 million women have an abortion each year. If only five percent of these women patients were to seek treatment for serious adverse psychological reactions to the procedure, there would be 80,000 additional women seeking mental health treatment each year. If that many women sought treatment for abortion-related problems each year, it would be clearly evident in our mental health system. According to testimony presented on behalf of the American Psychological Association, "If severe reactions were common, there would be an epidemic of women seeking treatment. There is no evidence of such an epidemic."[111]

## Other Public Health Concerns

■ MATERNAL AND INFANT MORTALITY. The availability of safe abortion services has been associated with declines in maternal mortality. Maternal mortality in New York State fell by 26 percent in the years immediately following the state's legalization of abortion in 1970. In contrast, maternal mortality fell by only 16 percent during the same years in states where abortion was illegal except in cases of life endangerment.[112] One researcher has

estimated that the legalization of abortion, and the subsequent reduction of both unwanted childbirth and illegal abortion, prevented 1,500 pregnancy-related deaths nationwide by 1983.[113]

Because many of the women who have an abortion are at high risk of a poor pregnancy outcome, legal abortion has also been associated with a reduction in the proportion of infants born at low birth weight and a decrease in the neonatal mortality rate (the number of infants who die during their first month per 1,000 live births). The availability of legal abortion was the single most important factor in the significant decrease in neonatal mortality between 1964 and 1977. Abortion alone was responsible for a reduction of 1.5 neonatal deaths per 1,000 live births among whites and 2.5 per 1,000 live births among blacks.[114] According to a recent Institute of Medicine study, the data "suggest that the significant increase in the availability of abortion between the late 1960s and the mid-1970s contributed to the gradual decline in low-birth-weight rates over the same period, although the magnitude of the influence has not been well-defined."[115]

Thousands of couples at high risk of bearing children with severe disorders are willing to become pregnant only because they know that prenatal genetic testing and abortion services can help prevent the birth of a seriously impaired child. Further, the number of infants born with Down syndrome in 1976 in the state of Washington would have been 64 percent higher, without legal abortion; 43 percent of the decline in the number of Down syndrome cases in Hawaii between 1963–1969 and 1971–1977 was due to legal abortion.[116]

■ WOMEN'S FUTURE CHILDBEARING ABILITY. Since 70 percent of the women having an abortion in 1987 said they intended to have children in the future, any adverse effect on a woman's ability to bear healthy children in the future would be cause for serious concern.[117]

In an attempt to examine these risks, researchers from the Centers for Disease Control and The Population Council conducted an extensive review of the worldwide literature on the effect of abortion on future childbearing ability.[118] After examining studies from 21 countries, including the United States, they concluded that vacuum aspiration does not pose a measurable risk to a woman's future childbearing ability.

Compared with women who carry their first pregnancies to term, women who terminate their first pregnancies by a vacuum aspiration abortion are at no greater risk of subsequent infertility or ectopic pregnancy. A single induced abortion performed by vacuum aspiration—the method used in more than nine out of 10 abortions in the United States today—does not increase the risk

of miscarriage, stillbirth, infant mortality or congenital malformations.[119] Further, a woman who has a vacuum aspiration abortion is at no added risk of either having a low-birth-weight infant or suffering major complications during future pregnancies or deliveries.

The researchers further concluded that studies of the effects of multiple abortions "do not support a firm conclusion about whether the number of induced abortions per se produces any increased risk of adverse outcomes in subsequent . . . pregnancies." While some studies have linked multiple abortions to future difficulty in bearing children, the abortions most frequently implicated were performed using the D&C method, which is rarely used for abortions in the United States today.

In short, while a single abortion does not appear to have any adverse implications for subsequent childbearing, less research has focused on multiple abortions performed using modern surgical procedures or second-trimester abortions. Additional research is necessary to determine whether they have an impact on a woman's future ability to bear healthy children.

## Health Implications of Restrictions on Abortion

Over the past two decades legal abortion has meant that millions of American women have been able to obtain an early, safe abortion. In 1989, however, the Supreme Court took what may be a major step toward reversing the progress made over the past two decades and may have placed the United States at a crucial turning point, not only in terms of women's rights but also in terms of public health.

Although the Court's 1989 ruling in *Webster* v. *Reproductive Health Services* did not exclude abortion from the constitutionally protected right to privacy, it signaled that a myriad of state-enacted restrictions on abortion, which had previously been found to be unconstitutional by the Court, might now be permitted.[120] Specifically, a plurality* of the Court discarded the trimester system that has formed the basis for the regulation of abortion for the last 17 years, declaring it to be "unsound in principle and unworkable in practice." Further, the Court said that the state's interest in potential human life, which under *Roe* could form the justification for restrictions on abortion only after a fetus reached viability, would now be considered compelling throughout pregnancy: "We do not see why the state's interest in protecting potential human life should come into existence only at the point of viability, and that there should therefore be a rigid line allowing state regulation after viability but prohibiting it before viability. . . ."[121]

For now, *Roe* v. *Wade* remains on the books, but its future, and the future of legal abortion in this country, is in doubt. In a strongly worded dissent, Justice Blackmun, *Roe*'s author, said that *Webster* "implicitly invites every state legislature to enact more and more restrictive abortion regulations in order to provoke more and more test cases, in the hope that sometime down the line the Court will return the law of procreative freedom to the severe limitations that generally prevailed in this country before January 22, 1973."[122]

Many state legislatures are now considering a variety of measures that, to one extent or another, would restrict access to safe, legal abortion services. While some states might attempt to ban abortion altogether, many can be expected to place limitations on obtaining the procedure. Included among the restrictions states are likely to consider are many that have been enacted over the last 17 years. While most of these measures have been held unconstitutional in the years since *Roe* v. *Wade*, their proponents are hoping that they can now pass constitutional muster.

Since 1973, for example, 14

*Three justices—Rehnquist, White and Kennedy—signed the plurality opinion. Justice O'Connor, in a previous opinion, said she considers the trimester system to be "on a collision course with itself," and Justice Scalia has said that he would overturn *Roe* outright.

states* have enacted a total of 17 laws requiring or permitting some form of spousal involvement in a woman's decision to have an abortion.[123] Sixteen states† have enacted 25 laws requiring physicians to give a prospective patient a precise listing of information before she can be considered to have given informed consent.[124] Twenty-one states‡ have enacted 28 laws requiring a woman to wait a prescribed amount of time between when she consents to an abortion and when the procedure is performed.[125] Almost all of these laws have been held unconstitutional when challenged in court.

In the 17 years since *Roe* v. *Wade*, 30 states§ have enacted 59 different laws requiring some form of parental involvement when a minor wants an abortion.[126] When these laws have given parents an absolute veto over their daughter's decision, the Court has found them to be unconstitutional. However, when a state provides for an alternate route for a minor, such as a court proceeding, statutes mandating either parental consent or notification have been upheld. Whether this so-called judicial bypass will continue to be a requirement for Court approval is uncertain.[127]**

For years, public opinion polls have consistently shown that the overwhelming majority of Americans oppose making abortion illegal again.[128] Yet, many Americans also appear to be concerned that there are "too many" abortions and that abortions should, in some undefined way, be not so "easy" for women to obtain. Increasingly, state legislatures will be under pressure to translate these sometimes ambiguous public concerns into legislative proposals. Many of the proposals that are likely to come before state legislatures might appear, at first glance, to be reasonable and even designed to protect the interests of pregnant women who are considering abortion. In reality, most are designed with one goal in mind—to prevent women from obtaining abortions. Americans' concerns about

*Florida, Idaho, Illinois, Kentucky, Louisiana, Missouri, Montana, Nebraska, Nevada, North Dakota, Pennsylvania, Rhode Island, South Dakota and Utah.

†Delaware, Idaho, Illinois, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Nebraska, Nevada, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah and Wisconsin.

‡Arizona, Arkansas, Delaware, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, West Virginia and Wyoming.

§Alabama, Arizona, Arkansas, California, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, West Virginia, Wyoming.

**On the same day it decided *Webster*, the Supreme Court announced that it would hear three additional abortion cases. Two of these cases—*Hodgson et al. v. State of Minnesota* and *State of Ohio v. Akron Center for Reproductive Health*—involve parental notification laws that include a judicial bypass alternative for minors who do not want their parents to know about their abortion. The third case, *Turnock v. Ragsdale*, which involved an Illinois licensing law and regulatory scheme that would require any facility—including a doctor's private office—that provides abortions, even in the first trimester, to meet stringent regulations, was settled before the Court was scheduled to hear oral arguments.

abortion are legitimate and deserving of respect and attention. However, legislation put forward to "regulate" abortion must be given careful consideration.

One of the most important yardsticks against which proposed legislation can and should be measured is its effect on women's health and safety and the discriminatory impact it might have on poor women, on minorities or on women in certain areas of the country. Each of the restrictions states are likely to consider would have its own unique effect on women seeking abortion services. But many of the restrictions would share a common outcome. Whether they reduce the number of abortion providers, increase the cost of the procedure, necessitate long-distance travel to receive abortion services or impose administrative obstacles for women to overcome—these measures would delay abortions and thus increase the health risks to women. Nearly two decades of progress in women's health could be reversed.

Some of the current and proposed restrictions are examined below.

### Mandatory Partner And Parental Involvement

Most Americans believe that the decision whether or not to have an abortion ultimately must be left up to the woman involved.[129] Many people, however, also believe that a woman's husband or partner should have some say in the decision. And most people feel that parents have both rights and responsibilities concerning their minor children's lives and, in particular, the medical care they receive. However, laws mandating third-party involvement in the abortion decision are fraught with problems; they are generally unworkable and they hinder a woman's ability to have an abortion early in pregnancy—when it is safest and least costly—and, for some, to have an abortion at all.

■ SPOUSAL/PARTNER CONSENT OR NOTIFICATION. Since *Roe* v. *Wade*, several states have enacted legislation requiring that a woman's husband or partner either be notified or formally consent to her decision to obtain an abortion. In reviewing such a requirement, the Supreme Court agreed that there is a value to communication between spouses or partners on such an important matter. However, the Court ultimately concluded in 1976 that because it is the woman who is pregnant and because the physical demands of childbirth are hers and hers alone, a husband or partner should not be able to exercise an absolute veto over her decision to have an abortion.[130]

In practice, laws mandating spousal involvement, either by notification or consent, are either unnecessary or unworkable for many women. One study found that 93 percent of married women having an abortion had informed their husband. Of the few who

had not, some said they did not because they had been raped by their husband or someone else, they feared physical and verbal abuse or they had other marital problems.[131] Eighteen percent of married women who live with their husband and have an abortion cite problems with their relationship as one of the reasons for which they are terminating their pregnancy.[132] In addition, six percent of abortion patients, almost 100,000 women, are legally married but are separated and not living with their husband (see Figure 6).

Instead of requiring the involvement of the husband, some laws have required the "father" of the fetus to be involved in the decision to have an abortion. If a couple is married, the husband would be assumed to be the "father." However, 81 percent of all women who had an abortion in 1987 were not married or were widowed, divorced or separated; two-thirds had never been married. As noted above, unmarried women are five times as likely as married women to have an abortion (see page 16).[133]

If the woman is not married, paternity would have to be established before any parental rights are asserted. The spousal involvement statute that was introduced in the Illinois state legislature in 1989 requires that paternity be established "by a preponderance of the evidence."[134] While plausible in theory, proving paternity, if contested, is virtually impossible in practice, since the technology is expensive, is not readily available in many areas of the country and requires several weeks to yield conclusive results, by which time an abortion would be either many times more dangerous for the woman or out of the question entirely.[135]

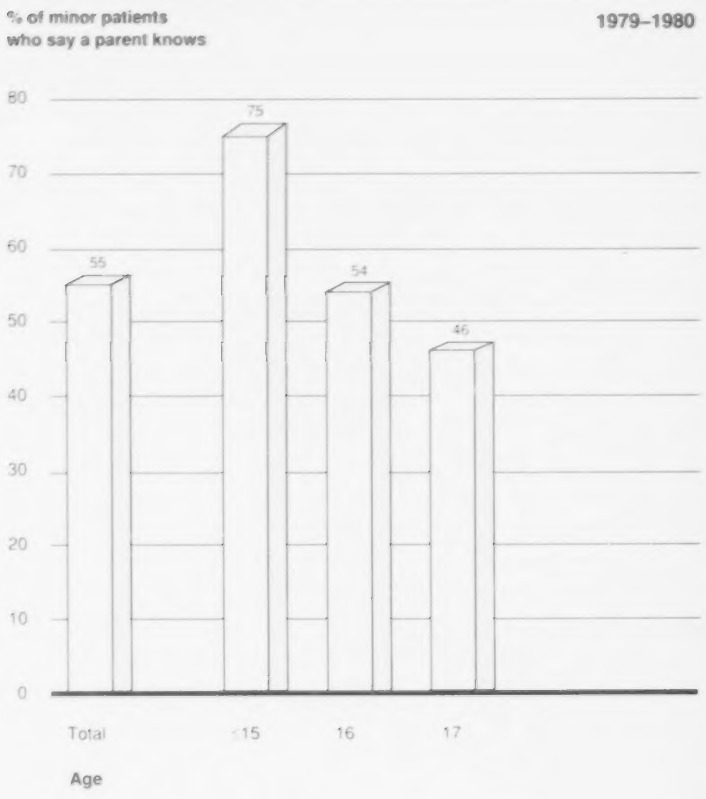
■ PARENTAL CONSENT OR NOTIFICATION. The question of whether states should require that parents be involved in their minor daughter's abortion decision—either by giving their consent or by being notified beforehand—is one of the most difficult public policy issues related to abortion. Most teenagers—especially young teenagers—have different decision-making capabilities and different emotional needs from adults. Most people agree that adult involvement can often help teenagers who are facing an unwanted pregnancy by providing support and guidance.

Even without specific legal requirements for parental consent or notification, most teenagers say that their parents know about their abortion (Figure 17).[136] Fifty-five percent of all abortion patients aged 17 and younger say that at least one parent knows of their decision, primarily because the minor told them voluntarily (38 percent). The younger the patient, the more likely her parents are to know; even in states where there is no mandated parental involvement, three-quarters of abortion patients 15 and under say at least one parent knows of their decision.

However, the policy debate focuses largely on those minors who, for one reason or another, feel they cannot involve their parents or who want an abortion and believe, rightly or wrongly, that their parents would want them not to have one. For some teenagers needing certain kinds of medical services, mandatory parental consent or notification could cause them to delay or forgo seeking care. This problem is not unique to abortion. Although parental consent or notification is generally sought before minors are given medical treatment, exceptions are made under most state laws in cases of emergency care or for certain sensitive services such as prenatal care, family planning, mental health services or the treatment of sexually transmitted diseases—where a requirement that parents be informed could deter some minors from receiving care.[137]

For many teenagers, a requirement that both parents be informed of their abortion can cause extensive delay or bar them from having an abortion altogether. Nearly 30 percent of girls 15–17 years old do not live with both parents; five percent live with neither parent.[138] Some may not have seen a noncustodial, nonresident parent in several years and may have no way of locating him or her. Thirty-six percent of children who live with their mother in a one-parent household say they have had no contact with their father in the last five years or do not know whether he is still living; 52

**Figure 17. Most minors having an abortion say that at least one parent knows; the younger the teenager, the more likely a parent is to know.**




**Source:** A. Torres, J. D. Forrest and S. Eisman, "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," *Family Planning Perspectives*, **12**:284, 1980.

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percent say they have not had any contact with their father in the last year.[139]

Involving parents in a way that meets the legal requirements can be very time-consuming as well. Minnesota, for example, requires notarized proof that the parents have been informed.[140] Ohio requires the physician to give notice to a parent or guardian personally before performing an abortion, also a potentially time-consuming process that could significantly delay the abortion if a separate appointment is needed.[141]

In fact, the record shows that state parental involvement statutes increase the health risks to some teenagers by delaying abortions. In the first eight months after Massachusetts adopted a parental consent requirement, the number of teenagers who left the state for an abortion increased by 300 percent.[142] This travel delayed teenagers' abortions by an average of 4.2 days, and some were delayed by nearly six weeks.[143]

After Minnesota adopted its parental notification requirement, many minors sought approval of a judge instead. These court proceedings routinely delayed abortions by more than one week, and sometimes by up to three weeks.[144] The proportion of minors having second-trimester abortions in Minnesota increased by 12 percent after the state law was enacted; at the same time, the number of women 18 and older having second-trimester abortions in the state decreased by one percent.[145*]

Currently, alternatives to mandatory parental or judicial consent or notification laws are being explored. For example, legislation enacted by Maine in 1989 offers a minor an array of "adult guidance" options from which she can choose, depending on her situation and needs. This legislation allows an adult family member aside from the minor's parent to consent to the procedure. Alternatively, the minor may give informed consent herself after being counseled by a physician or another responsible member of the community, such as a mental health professional, a member of the clergy or a guidance counselor.[146]

### Waiting Periods And "Informed Consent"

There is general agreement that the decision to have an abortion should not be made lightly, and that a woman should have all the information and all the time she needs to consider her options and make an informed decision. Attempts by several states to translate these principles into legislation—either by mandating a waiting period before a woman can obtain an abortion or by requiring that she be given specific information before having an abortion—have met with little success. It is not clear that such mandates have proved to be of any use in promoting

*The data compare the average of 1978–1980 with the average of 1982–1983.

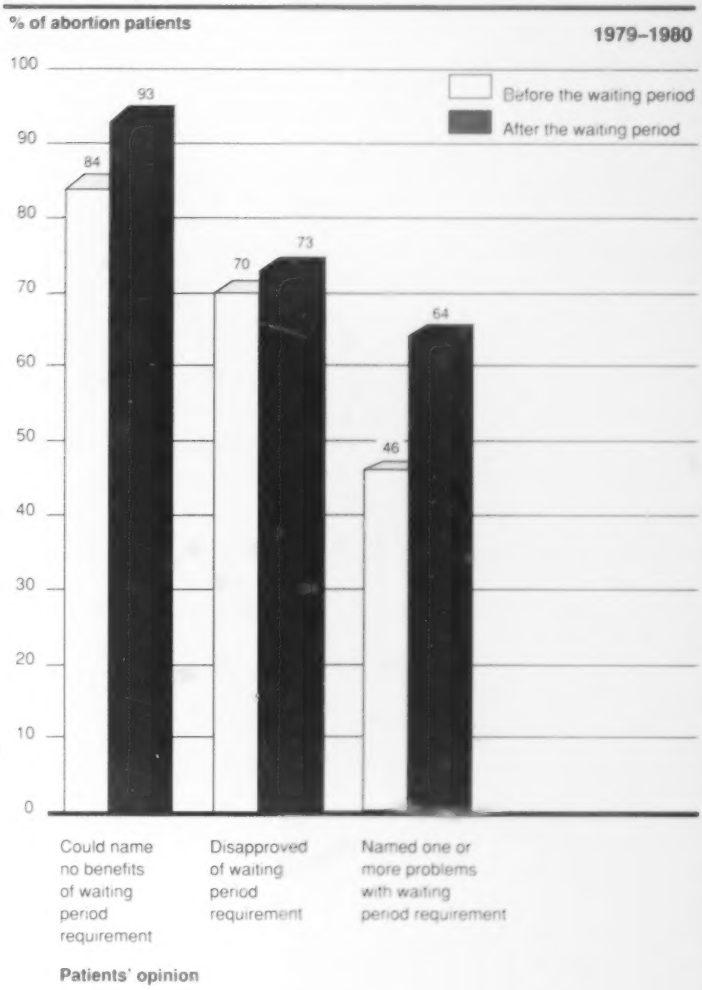
informed decision-making. Instead, they intrude into the normal patient-physician relationship and may cause women to delay obtaining an abortion.

■ WAITING PERIOD REQUIREMENTS. Women faced with an unwanted pregnancy do not make decisions about abortion lightly or alone. Almost all women having an abortion say they have more than one reason for wanting the procedure. On average, women give four different reasons for wanting to terminate their pregnancy (see page 19).[147]

A 1981 study found that 88 percent of the women who came to several abortion clinics in Tennessee said they had consulted at least one person before coming to the clinic.[148] Forty-two percent said they had consulted their partner, 35 percent said they had consulted a close friend, 17 percent said they had talked with their mother and two percent said they had talked with a minister or a guidance counselor.

This same study found that 64 percent of abortion patients surveyed in Tennessee said that the state-required 48-hour waiting period caused problems such as additional mental anguish, additional costs and additional physical discomfort. Seventy-three percent said they disapproved of the requirement (Figure 18). Ninety-three percent were unable to name a single benefit they had experienced by being required to wait to have their abortion.[149] In reviewing a 24-hour waiting period require-

**Figure 18. Abortion patients disapprove of a waiting period requirement—even more strongly after the waiting period is over.**




**Source:** M. Lupfer and B. G. Silber, "How Patients View Mandatory Waiting Periods for Abortion," *Family Planning Perspectives*, 13:75, 1981.

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ment in 1981, the Supreme Court concluded that proponents of the provision "failed to demonstrate that any legitimate state interest is furthered by an arbitrary and inflexible waiting period. . . . Nor are we convinced that the state's legitimate concern that the woman's decision be informed is reasonably served. . . ."[150]

For all women, a waiting period, by definition, delays an abortion. For any woman who cannot schedule a second appointment promptly, the delay could be lengthy. Since abortion providers are concentrated in metropolitan areas of the United States, for some women—especially the six percent of abortion patients who cross state lines to terminate their pregnancy, as well as many of the women who travel sometimes long distances within their own states—the necessity of returning for a second appointment could easily delay an abortion significantly.[151] In addition, requiring a second trip would double the woman's transportation and lodging costs. It would also entail additional time missed from school or unpaid time away from work for the 31 percent who are enrolled in school and for the 68 percent of abortion patients who are employed (see Figure 6).[152]

■ "INFORMED CONSENT" REQUIREMENTS. Informed consent is one of the most deeply rooted traditions in American medicine, reaching back to English common law.[153] In 1982, the congressionally chartered and presidentially appointed President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that the ethical foundation of informed consent is based on the promotion of two values: personal well-being and self-determination.[154] "Patients who have the capacity to make decisions about their care must be permitted," according to the Commission, "to do so voluntarily and must have all relevant information regarding their condition and alternative treatments, including possible benefits, risks, costs, other consequences, and significant uncertainties surrounding any of this information. This conclusion has several specific implications: Although the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative. Ethically valid consent is a process of shared decision-making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form. . . ."[155]

Health care providers are bound by the standards of their profession to obtain a patient's voluntary and fully informed consent. The Principles of Medical Ethics of the American Medical Association recognize that "the patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."[156]

The standards of the major organizations to which most abortion providers belong em-

body these principles. The American College of Obstetricians and Gynecologists specifies that "in the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy."[157] *Standards for Abortion Care* of the National Abortion Federation (NAF) (whose members perform approximately 50 percent of all abortions in the United States) states: "It is the responsibility of each abortion provider to ascertain prior to the performance of an abortion that the patient understands and has freely chosen to terminate her pregnancy."[158]

Nonetheless, several states have enacted legal mandates that women be given a specific list of state-approved information prior to having an abortion. Typically, this information includes a detailed discussion of fetal development—often at two-week intervals for the entire course of a pregnancy from conception to delivery—and specific information on the risks of abortion at all stages of pregnancy. After reviewing such requirements, the Supreme Court concluded in 1983 that they forced physicians to present "a parade of horribles" that "is designed not to inform the woman's consent but rather to persuade her to withhold it altogether."[159]

In addition, to comply with such a state law, a physician would have to give a patient information completely unrelated to her particular medical situation and to inform her of risks that are not relevant to her.

## Government Regulation Of Abortion Facilities

The public's concern that abortions be performed safely is certainly justifiable. Ostensibly to further this objective, several states have required some form of licensing for outpatient abortion clinics. Some states also have required that all abortions after a certain point in pregnancy be performed in hospitals. One yardstick against which these requirements are measured is whether such regulations would make abortions safer or whether, in fact, they would place an inappropriate burden on providers that may force some to incur unnecessary expenses and thus to increase their fees and others to cease to offer abortion services altogether.

■ CLINIC-LICENSING REQUIREMENTS. Eighty-seven percent of abortions in the United States today are performed in clinics and physicians' offices.[160] The data show that abortions are as safe when performed in outpatient facilities as when they are performed in hospitals, at least until the middle of the second trimester for women who are not at high risk.[161] Several safeguards exist that ensure the well-being of a woman obtaining an abortion in an outpatient facility.

A 1981 survey of abortion clinics nationwide found that over two-thirds are licensed by state, county or local governments.[162] In some places, a clinic needs to obtain a license from all three; in some areas, clinic licensing is compulsory and in others it is optional. Licensing procedures typically require that both the staff and the physical facilities of the clinic are adequate to provide quality care. In most cases, the licensing procedure entails on-site inspections of the clinic; in all instances, licenses may be revoked if violations are found.

State medical boards can provide another layer of protection. These peer-review panels are charged with ensuring that medical care is delivered safely and in a manner consistent with the standards of the profession. These boards often have wide latitude to see that unsafe practitioners are unable to practice medicine in the state.

In addition, many clinics are subject to the standards established by their respective national organizations. Members of NAF, for example, agree to adhere to comprehensive national standards governing counseling, nursing care, preoperative and postoperative care, surgical procedures, drugs and medication, equipment and the qualifications of counseling and medical personnel.[163] An affiliate of the Planned Parenthood Federation of America may offer abortion services only after the abortion facility is inspected and approved by the organization's National Medical Division. To provide abortions, a Planned Parenthood affiliate must have appropriate and adequately trained staff and its physical facilities must meet strict national standards.[164]

Recently, in the name of promoting the safety of abortion services, some have proposed greatly expanding the physical plant requirements that free-standing abortion clinics must meet by forcing clinics to become the "functional equivalent of small hospitals" in order to continue to provide abortion services.[165] For example, regulations promulgated in Illinois would mandate specific corridor widths and sex-segregated locker rooms, even though the record indicates that such measures are unrelated to the practice of safe abortion care and would do nothing to ensure that services are provided by skilled personnel under sanitary conditions.[166]

While such requirements would not be effective in promoting safety, they would force large numbers of abortion facilities to close. A survey of 254 abortion clinics that collectively provide 560,000 abortions each year—more than one-third of all abortions performed in the United States—found that 98 percent of the clinics could not meet all the requirements of the Illinois regulations; 75 percent of the clinics would be forced to attempt to relocate if required to adhere to the regulations.[167]

A decrease in the availability of outpatient abortion facilities would have serious effects on

women's health. First, some women would have to delay their abortion while attempting to locate an abortion facility that may end up being a long distance away. In addition, a decrease in clinic facilities would result in more women having to pay the higher cost of a hospital abortion or travel to a clinic further away.

■ IN-HOSPITAL REQUIREMENTS. Presumably to ensure that abortions are performed safely, several states have enacted requirements that abortions, especially in the second trimester, be performed in hospitals rather than in freestanding outpatient clinics.[168]* While some women should have their abortion in a hospital because they have particular health problems or because of the type of abortion procedure they will undergo, requirements that *all* women have abortions in hospitals have no medical rationale. (Similarly, prohibitions on *any* abortions in hospitals also are problematic; see p. 53). After a careful review, researchers from the Centers for Disease Control concluded that abortions may be performed as safely in nonhospital settings as in hospitals, at least until the middle of the second trimester of pregnancy for women who are not considered to be high-risk.[169] Further, the Standards of the American College of Obstetricians and Gynecologists classify abortions as appropriate procedures to be performed in physicians' offices or outpatient clinics during the first 14 weeks of pregnancy.[170]

Requiring that abortions be performed in hospitals could seriously restrict access to abortion services. Only one in five general, short-stay hospitals in the United States provides abortion services.[171] No hospital in North Dakota, for example, performs abortions, while in 12 other states, fewer than four hospitals offer abortion services.[172] When asked in a 1983 study why they did not perform abortions, nine percent of general practitioners, surgeons and obstetrician-gynecologists said that the hospitals in which they practice prohibit abortions.[173]

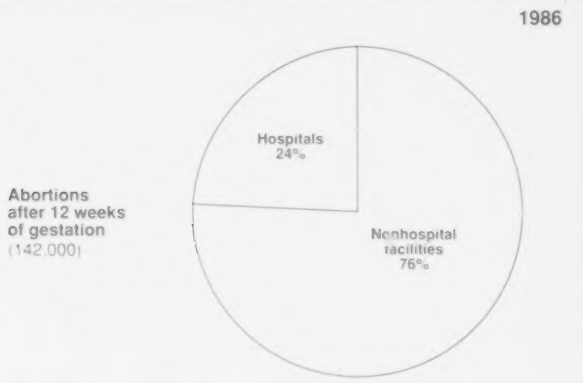
A hospital requirement would make it particularly difficult for women to obtain an abortion after the first trimester. Only 46 percent of hospitals in which abortions are performed offer abortions after the first trimester, compared with 62 percent of clinics.[174] In nine states, no in-hospital second-trimester abortions were performed in 1985.[175] Currently, 76 percent of all second-trimester abortions are performed in nonhospital facilities; only 24 percent are performed in hospitals (Figure 19).

Because abortions in hospitals typically are two to three times as expensive as abortions in nonhospital settings, a hospital requirement would also make abortions

*In *Roe v. Wade*, the Court said that with the technology existing in 1973, restricting abortions after the first trimester to hospitals could be justified as necessary to protect the health of the woman. In *City of Akron v. Akron Center for Reproductive Health* in 1983, the Court acknowledged that medical advances no longer justified such a restriction.

significantly more expensive, a particular burden for low-income women. Sixty-nine percent of obstetrician-gynecologists who perform abortions only in hospitals decline to reduce their fees for low-income women, compared with only 53 percent of those who perform abortions in both hospital and office settings. Only 23 percent of the physicians who perform abortions only in hospitals accept Medicaid payments, compared with 38 percent of those who perform them in both hospitals and their offices.[176]

**Figure 19. Because three-quarters of second-trimester abortions are now performed in nonhospital facilities, limiting second-trimester abortions to hospitals would affect many women.**




**Sources:** S. K. Henshaw, unpublished tabulations of data from a nationwide Alan Guttmacher Institute survey of abortion providers, 1985; and S. K. Henshaw and J. Van Vort, eds., *Abortion Services in the United States, Each State and Metropolitan Area, 1984–1985*, The Alan Guttmacher Institute (AGI), New York, 1988, updated for 1985 from Centers for Disease Control and AGI data



## "Keeping Government Out Of the Abortion Business"

Public opinion polls have shown that while most Americans believe abortion should be legal, many nonetheless believe that the government should have no role in providing or supporting abortion services.[177] However, the Medicaid program, established in 1965, was designed to meet two major and related objectives: to increase access to the nation's health care system by individuals "whose income and resources are insufficient to meet the cost of necessary medical services," and, by so doing, to "help such families and individuals attain or retain capability for independence or self-care."[178] At the same time, both public and private hospitals serve a wide cross-section of women, including women on Medicaid, poor women who are not eligible for Medicaid and more affluent women. Prohibiting these public

programs and facilities from providing abortion services has no medical rationale, discriminates against poor women and can be extremely costly.

■ BANNING PUBLIC FUNDING. Nine percent of women of reproductive age rely on Medicaid for their medical care.[179] As a result of legislation enacted by Congress after *Roe* v. *Wade* and upheld by the Supreme Court, federal Medicaid funds may be used for an abortion only if the life of the woman is endangered.[180] Only 13 states* continue to use their own revenues to provide medically necessary abortion services for their low-income residents.[181]

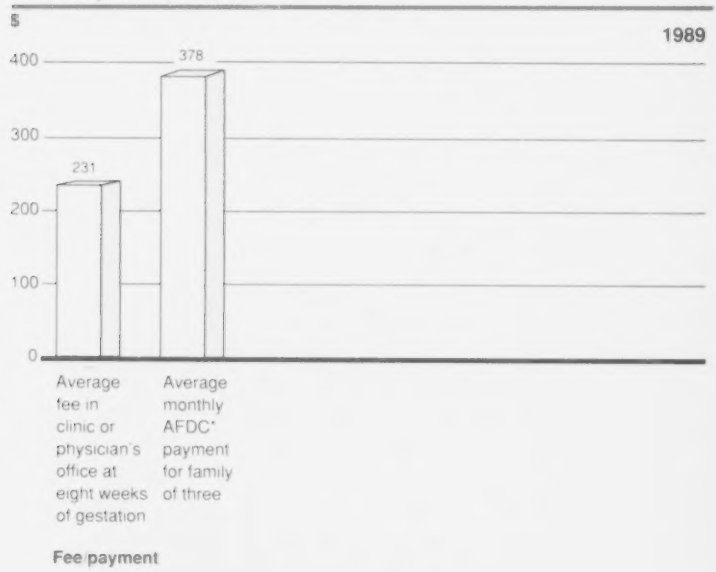
The average fee for an abortion in a clinic at eight weeks, $231, is more than half the average monthly income of a family on Medicaid† (Figure 20).[182] As a result of the prohibition on the use of public funds, 20 to 25 percent of the women who would have had publicly funded abortions are unable to pay for an abortion on their own and therefore carry their unwanted pregnancies to term.[183]

If public funds are not available to pay for abortions, a far greater amount of money will be spent to provide maternity care, medical care for the infant, Aid to Families with Dependent Children

*Alaska, Hawaii, Maryland, New York, North Carolina, Oregon, Washington, West Virginia, California, Connecticut, Massachussetts, New Jersey and Vermont.

†The average maximum monthly Aid for Families with Dependent Children payment for a family of three was $378 as of July 1989.

**Figure 20. It is difficult for a poor woman to afford an abortion—the fee represents more than half a family's monthly welfare check.**




*AFDC = Aid to Families with Dependent Children.

**Sources: Fee for abortion**—R. B. Gold, unpublished tabulations of data from *National Abortion Federation Membership Directory*, Washington, D.C., 1989. **AFDC payment**—I. Hill, National Governors' Association, memo, Aug. 17, 1989.

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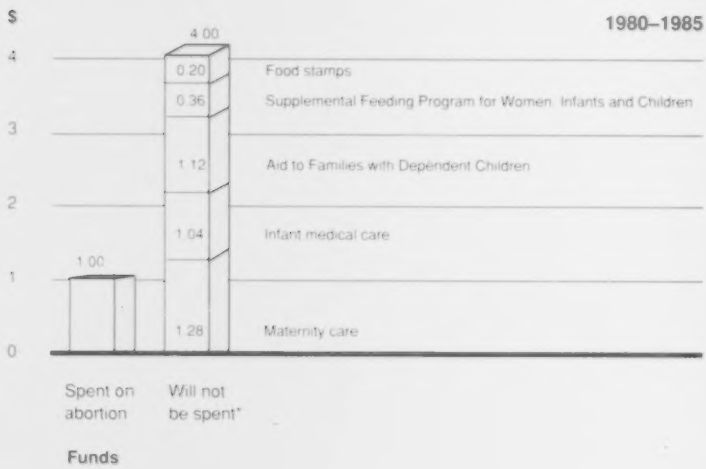
and nutritional assistance to women on Medicaid. For every dollar of public funds that is spent to provide an abortion for a low-income woman, the expenditure of four dollars in public funds is avoided just in the first two years following birth (Figure 21).[184]

A small percentage of the women who would have a publicly funded abortion if there were no funding restriction attempt illegal or self-induced abortions.[185]

Of the women who would obtain a publicly funded abortion, 75–80 percent are able to raise the money to pay for the abortion themselves, albeit often at a high cost to themselves and their family. These women are far more likely than other patients to say they had to let bills go unpaid or to buy less food or clothing to pay for their abortion. Nearly 60 percent of Medicaid patients, compared with 25 percent of more affluent patients, say that paying for the procedure entailed serious hardship.[186]

Moreover, it often takes considerable time to obtain the money needed to pay for an abortion. While not all Medicaid-eligible women are forced to delay their abortion, many abortions are delayed by as much as two to three weeks. In 1982, after the funding ban was put into place, 50 percent of the Medicaid-eligible patients at one clinic had their abortion after nine weeks of pregnancy, compared with only 37 percent of non–Medicaid-eligible women (Figure 22).[187]

**Figure 21. For every dollar spent on a publicly funded abortion, four dollars in public funds will *not* have to be spent.**




*In the two years following childbirth.

**Source:** A. Torres et al., "Public Benefits and Costs of Government Funding for Abortion," *Family Planning Perspectives*, **18**:111, 1986.

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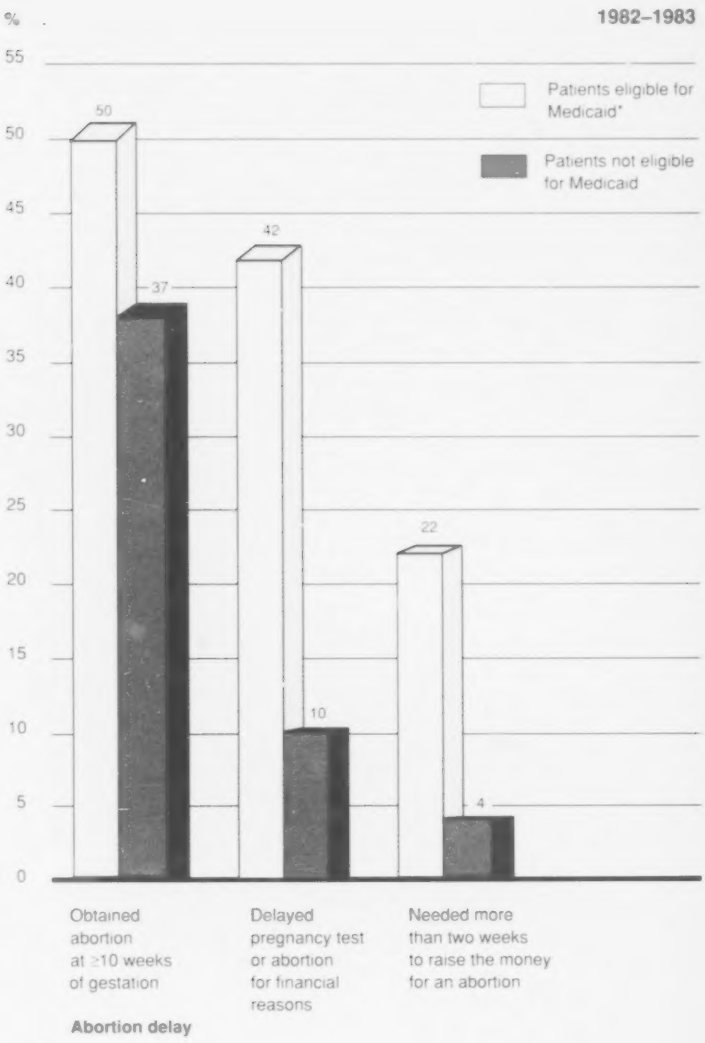
Further, 22 percent of Medicaid-eligible women who had a second-trimester abortion after funding was restricted would have been able to have the procedure in the first trimester if they had not had to delay for financial reasons.[188]

■ BANNING ABORTIONS IN "PUBLIC" FACILITIES. In *Webster* v. *Reproductive Health Services*, the Supreme Court upheld a Missouri law banning abortions in public hospitals, even if the woman paid the entire fee for the procedure herself and no public funds were used. For purposes of the law, Missouri considered any hospital leasing land or facilities from state, local or county governments to be a public facility.[189] Because almost all hospitals have some involvement with the public sector—if only by participating in Medicaid and Medicare—a prohibition on abortions in "public" facilities could prohibit abortions in many institutions generally considered to be private hospitals.

The low and declining rate of hospital participation presents a growing problem. While most abortions can be (and are) performed safely in nonhospital settings, some are appropriately performed in hospitals. For example, women with complicated medical conditions often should be hospitalized for an abortion, as must those undergoing a late abortion, which often is performed for genetic reasons or because the woman's health is at risk. In addition, many low-

**Figure 22. Where public funds are not available, poor women have their abortion later than do those who are more affluent.**




*In the state (Missouri) where women were surveyed, Medicaid did not pay for abortion except in cases of life endangerment.

**Source:** S. K. Henshaw and L. S. Wallisch, "The Medicaid Cutoff and Abortion Services for the Poor," *Family Planning Perspectives*, **16**:170, 1984.

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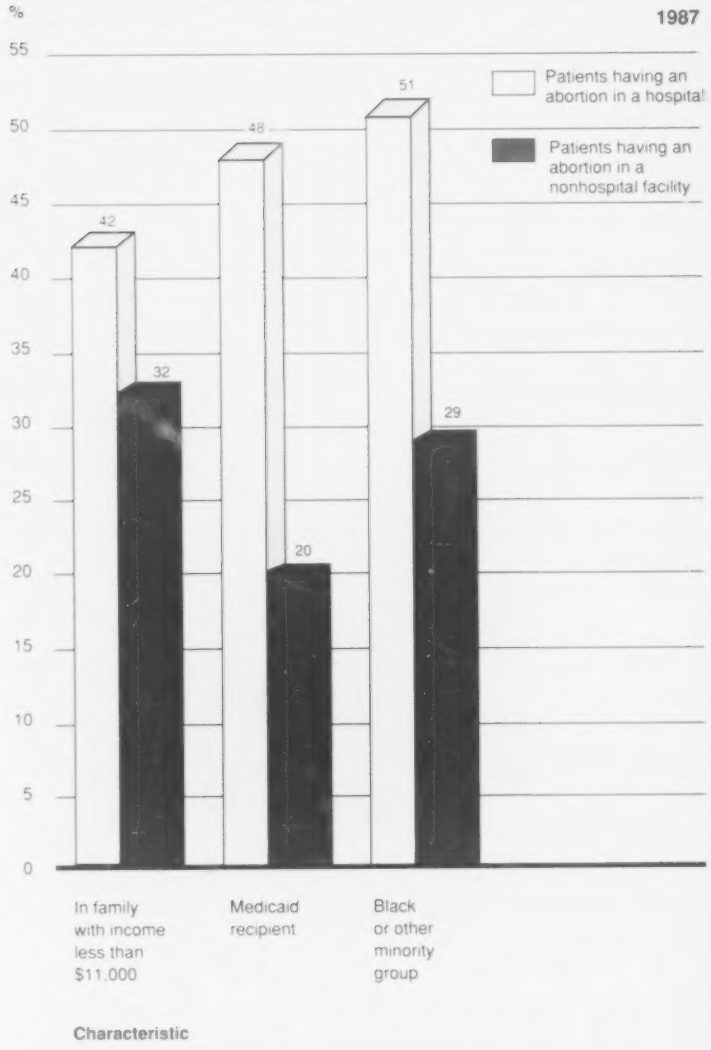
income women utilize hospitals for most of their medical care, and sometimes hospitals are the only source of such care in the community.

A ban on abortions in hospitals would significantly limit access to abortion services. In 33 percent of counties in the country with abortion facilities, the only abortion provider is a public or private hospital. In 13 percent, the only abortion provider is a public hospital.[190] Further, 53 percent of obstetrician-gynecologists who perform abortions do so only in hospitals, and another 38 percent perform some abortions in hospitals.[191]

Women who are low-income, eligible for Medicaid or members of a minority group are much more likely than more affluent women to have their abortion in a hospital, and therefore would be most affected by a ban on hospital abortions. Half of all women who have an abortion in a hospital are black or of another minority group, compared with 29 percent of the women who have their abortion in a clinic or a physician's office (Figure 23). Forty-two percent of women having an abortion in a hospital, compared with 32 percent of women having an abortion in a nonhospital facility, have an annual family income under $11,000.[192]

Even an exception that permits in-hospital procedures when necessary to save the life of the woman would nonetheless block access to care for women whose medical conditions indicate that

**Figure 23. Women who have an abortion in a hospital are disproportionately poor and from minority groups.**




**Source:** S. K. Henshaw, unpublished tabulations of data from a 1987 nationwide Alan Guttmacher Institute survey of 9,480 abortion patients.

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their abortion *should* be performed in a hospital. Among the women who could be denied hospital care would be high-risk women—those with severe, but not necessarily life-threatening medical conditions such as cancer, diabetes or human immunodeficiency virus (HIV) infection. Women with high blood pressure who are at high risk of developing serious complications from an abortion would also be precluded from having an abortion in a setting where additional medical care is easily available.

A restriction on abortions in hospitals would also be tantamount to prohibiting abortions in cases of severe fetal defects, because these procedures are almost always performed in hospitals. Shortly after the implementation of the law in Missouri banning abortions in hospitals that leased land from the state, for example, a woman who was carrying a fetus whose heart and abdominal organs were outside its chest and abdominal walls had to go to Kansas to have an abortion because she could not have the procedure in her own state.

A restriction on in-hospital abortions has serious implications for medical education, much of which takes place in hospitals, especially in public teaching hospitals. Approximately 25 percent of all hospitals in the country are teaching hospitals or academic medical centers.[194] Seventy-two percent of all residency programs in obstetrics and gynecology include training in first-trimester abortion services; 75 percent of all obstetrician-gynecology residents train in these programs.[195] Such restrictions on medical education would decrease the number of physicians trained and experienced in performing abortions safely.

■ RESTRICTING PUBLIC EMPLOYEES. Federal, state and local governments provide a wide range of medical services through public hospitals and health departments and finance a network of facilities that can include family planning clinics, community health centers, migrant health centers and sexually transmitted disease clinics. As a way of keeping the government distanced from abortion, some states are proposing prohibiting employees in such facilities from offering abortion counseling or referral unless the woman's life is endangered.[196*]

According to their 1982 study, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that the concept of informed

*This type of restriction was included in the Missouri law that was at issue in the *Webster* case. The Court, however, accepted the state's assertion that the denial of public funds for counseling or encouraging a woman to have an abortion not necessary to save her life applies only to state employees who are responsible for spending public funds, not to doctors or other health care providers, and that the issue was therefore moot because none of those challenging the law would be adversely affected under this interpretation. Similar restrictions have also been promulgated by the federal government concerning services provided through the Title X national family planning program; these regulations are not in effect, pending the resolution of several suits that have been filed to block their enforcement.

consent is rooted in the recognition that patients "are entitled to accept or reject health care interventions on the basis of their own personal values and in furtherance of their own personal goals."[197] The commission concluded that all relevant medical information, including information about alternative courses of treatment and the risks and benefits of each option, must be provided, even if the treatments are not offered or favored by the particular physician or facility.

Essentially, therefore, a restriction prohibiting public employees from providing such counseling would make a patient's ability to give informed consent to her medical care dependent on whether she obtained care from a public or a private source. Further, since most of the women who get care from employees at public facilities generally cannot afford care from a private physician, whether a patient is allowed to give fully informed consent would then become conditional upon her degree of impoverishment. This is in direct opposition to the findings of the President's Commission, which, after lengthy deliberations, concluded that informed consent is a basic standard, and should not be dependent upon a patient's income or source of care.[198]

In addition to denying patients the ability to give informed consent, such a prohibition would force public employees to violate the ethical codes of their own professions. Failure to comply with the patient's right to full information and self-determination constitutes a breach of the professional ethics of the American Medical Association and the American College of Obstetricians and Gynecologists, among other organizations.[199]

### Prohibiting Abortions Under Some Circumstances

While public opinion polls have consistently shown that most Americans believe that abortion should remain legal and available, they also reveal that most people believe there should be fewer abortions. This concern has given rise to numerous proposals to prohibit abortions in some circumstances. Some of these measures seek to prohibit "late" abortions, while others would prohibit abortions except for certain, limited reasons. A particularly thorny issue is raised by the prospect of abortions performed for purposes of gender selection.

■ PROHIBITING "LATE" ABORTIONS. Many Americans are deeply concerned about abortions performed late in pregnancy.[200] Although the overwhelming majority of abortions take place very early in pregnancy, just under four percent are performed after 15 weeks of pregnancy and one-half of one percent of all abortions are performed after 20 weeks.[201] Some 100–200 abortions are performed each year after 24 weeks of pregnancy.[202] "Late" abortions are difficult, emotionally and physically, for the

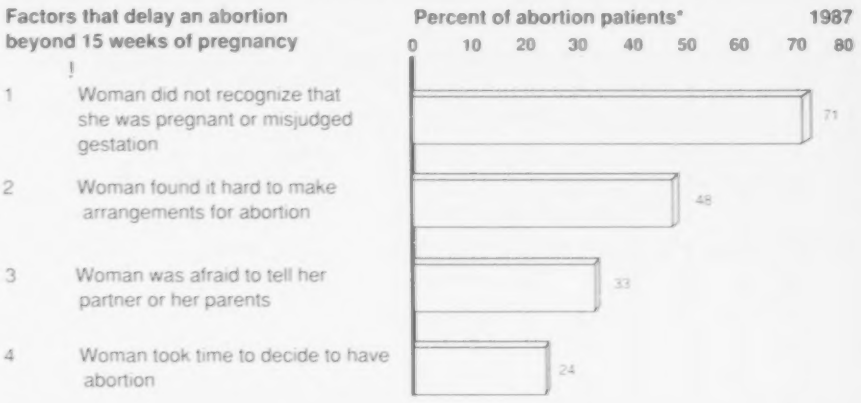
woman as well as for the medical team; all evidence shows that these procedures are not undertaken lightly.

In one study of women who were having an abortion at 16 or more weeks, the reason most frequently given for the delay was that the woman had not realized she was pregnant or had misjudged the time of gestation (71 percent) (Figure 24).[203] Half of these women said they had felt no physical changes, and a third said they had not recognized the pregnancy because of a history of irregular menstrual periods. One-quarter of the women said they needed time to make the decision. Many abortions after 15 weeks of pregnancy could perhaps be prevented with better sex education and improved access to the counseling and education offered by family planning clinics and others.

In the same study, nearly half of patients who were having an abortion at 16 or more weeks attributed the delay at least partially to difficulties in making arrangements. Twice as many women attributed the delay to finding funds to pay for the procedure as attributed it to other problems in making arrangements. Six in 10 women said that the delay occurred because they "needed time to raise money." Moreover, as pregnancy progresses, abortions become more expensive, and women need to raise additional funds.

Another difficulty is a lack of abortion providers. Only seven percent of all abortion providers

**Figure 24. Four major factors delay an abortion beyond 15 weeks of pregnancy.**




*Most women gave multiple factors.

**Source:** A. Torres and J. D. Forrest, "Why Do Women Have Abortions?" *Family Planning Perspectives*, **20**:169, 1988.

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will perform procedures past 20 weeks.[204]

The women who have an abortion after 15 weeks of pregnancy are disproportionately under 18, black, unemployed, poor enough to be eligible for Medicaid, pregnant as a result of rape or incest, or carrying a fetus diagnosed as having severe defects.[205] (Amniocentesis, the most common test to diagnose severe fetal defects, usually does not yield results before 18 or 19 weeks of pregnancy.) Abortions in cases of fetal defect are almost always performed after 20 weeks. Therefore, any prohibition on abortions after 20 weeks would be tantamount to prohibiting abortions in cases of severe fetal defect, even though eight in 10 Americans consistently have indicated that they believe abortions should be available in this situation.[206]

■ PROHIBITING ABORTIONS FOR CERTAIN REASONS. Virtually all Americans believe abortions should be available in the so-called hard cases, such as when the woman's life or health is endangered, when she has been sexually assaulted or when the fetus is found to be seriously diseased or malformed. However, some believe that abortion is used as a substitute for birth control. Various restrictions have been proposed that would stipulate the exact circumstances in which it is permissible for a woman to have an abortion. Some would prohibit abortion even if the woman's life or health is endangered, the fetus has a serious defect or the pregnancy is the result of rape or incest.

While some abortions are sought because of such reasons, most are not; there are many other reasons that the women themselves consider compelling. Most women who choose to terminate their unintended pregnancy are young and not yet in the type of familial, financial or economic situations in which they think children should be reared.[207] The major reasons that women give for having an abortion bespeak these concerns and indicate that these women are attempting to make the kinds of decisions that will enable them to care for children in the future. In one study, for example, while 70 percent of abortion patients said they would like to have children in the future, most said they were unready for the changes a child would bring. Two-thirds of these women said that a baby would make it difficult or impossible to hold a job and half said a baby would make it difficult or impossible to continue school (see Figure 8).

Most women who do not want to become pregnant use contraceptives to avoid pregnancy; 92 percent of women at risk of becoming unintentionally pregnant use some method of contraception.[208]

Recently, proposals have been made to prohibit patients from using the information gained from prenatal genetic testing, such as amniocentesis, to seek an abortion for the purpose of "sex

selection." Although no evidence exists that such sex selection is anything more than an extraordinarily infrequent occurrence, the prospect of an abortion being performed for this reason distresses many people.[209]

Most scholars and ethicists who have examined this issue have recommended against an outright legal ban, largely because such a prohibition would be unenforceable—"deception by patients would be easy."[210]* Some women could claim to be at risk of bearing a fetus with a sex-linked disorder. Further, one of the most common reasons for amniocentesis is the detection of Down syndrome, a risk that rises sharply in pregnant women over 35. Any pregnant woman over 35 could claim that she is having amniocentesis to rule out Down syndrome, even if, in reality, she is seeking to determine the sex of the fetus. A statute sufficiently strict to be enforceable would, of necessity, deny many pregnant women access to needed prenatal genetic diagnosis.

Another approach to this issue would be to prohibit doctors from telling prospective parents the sex of the fetus after prenatal genetic testing occurs. Unfortunately, that would place physicians in the difficult ethical position of withholding information asked for by their patients.

While most agree that abortions should not be done for purposes of sex selection, many ethicists are mindful that legal prohibitions would largely be ineffective in preventing these procedures. They have further concluded that using prenatal diagnosis for the purpose of sex selection would be more appropriately discouraged by the mechanisms already established in the national medical specialty associations and state medical societies than by legal prohibition.[211]

*Several prominent reviews of this issue—including a consensus development conference sponsored by the National Institutes of Health, a report from the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, an interdisciplinary group convened by the Hastings Center and an international meeting of geneticists—have all concluded that abortions should not be performed for purposes of gender selection.

## Afterword: A Turning Point?

**By Jeannie I. Rosoff**

The legalization of abortion, which was legislated by some states beginning in 1967 and was mandated for the country as a whole by the Supreme Court in 1973, represented the natural culmination of long-term social, philosophical and legal trends in the United States. In previous decisions, the Court had affirmed the fundamental human right of women and men to decide to have, or not to have, children without the interference of the government. It had also recognized constitutional protection of the use of contraceptives, first by married couples and later by individuals. In 1973, the Court extended this protection to a woman's decision to have an abortion, with few state-imposed limitations allowed in the early stages of pregnancy. Over the next decade, efforts to overturn *Roe* v. *Wade* through a constitutional amendment failed decisively in Congress and, until 1989, states' repeated challenges to the principle of reproductive freedom were rebuffed, time and time again, by the Court.

In 1989, however, a new majority of the Supreme Court emerged that questioned the constitutional validity of *Roe* v. *Wade*. In *Webster* v. *Reproductive Health Services*, the Court tacitly issued an open-ended invitation to state legislatures to once again regulate and sharply restrict access to legal abortion. In so doing, the Court also invited nationwide referenda on whether, when, why and under what circumstances a woman may decide to terminate her pregnancy. In the hurly-burly of the 50 state legislatures and the U.S. Congress, decisions will be made that will profoundly affect the fate of millions of American women and their families, as well as the future of the next generation.

The issues are emotionally charged and politically explosive. In the matters of giving birth and raising children, we all have opinions and we are all instant experts. In our definitions of human life and personhood, we all have beliefs. However, in addition to, and sometimes even more important than, these often conflicting views and values are facts, realities and consequences—individual and societal—that demand consideration.

Over the past two decades, a substantial body of knowledge about and experience with legal abortion in the United States has accumulated, particularly in regard to two issues that figured prominently in the movement to legalize abortion: safety and equity. Although the number of deaths resulting from illegal abortion decreased in the 1950s and 1960s, such deaths were still a major factor in maternal mortality

before 1973. And, not surprisingly, they were most common among women who did not have the resources, financial or otherwise, to travel long distances within the United States or abroad to obtain a legal abortion, to seek the approval for a legal abortion from a hospital committee on mental health or other grounds, or to obtain an illegal but medically supervised and relatively safe abortion.

Legal abortion, as performed in the United States today, has been shown to be an extremely safe surgical procedure. Moreover, there is no evidence that additional regulation of abortion services in the United States, including the enactment of many of the proposals presumably advanced in the interests of women's health, would make abortion services any safer for women. In fact, many of the types of regulations that have been proposed over the years would, if adopted, actually pose a serious threat to women's health by *reversing* the trend toward earlier, safer abortions. Rather, the two major restrictions on abortion that have been in effect in many states over the past several years have had well-documented negative consequences for women's health. Statutes requiring minors to notify or obtain the consent of their parents have frequently caused teenagers to travel far from home to terminate their pregnancy, often resulting in a delayed abortion. Likewise, the ban on Medicaid funding of abortion that is in effect in most states has forced some women to carry their unwanted pregnancy to term, frequently under rather unfavorable circumstances, and has forced others to delay their abortion until they could secure the necessary funds to pay for the procedure. It is clear that some groups of women—primarily the young, the poor and minorities—are to this day at a disadvantage in relation to others who wish to terminate their pregnancy. The experience of these disadvantaged groups indicates that additional restrictions would force progressively larger groups of women to delay abortion and face the attendant increased health risks or an outright inability to obtain a safe, legal abortion.

Nevertheless, it is also clear that although the overwhelming majority of Americans believe that abortion should remain legal, many believe that some restrictions are in order, because there are just "too many" abortions. Indeed, many other developed countries where abortion is also legal have considerably lower abortion rates than the United States. This is because the United States has a much higher incidence of unplanned pregnancy than do most other industrialized countries, resulting in a high rate of both abortion and unplanned birth.[212]

Many factors, by no means unique to the United States, are at play here, some of which do not seem capable of reversal or improvement through government intervention: early sexual maturation resulting from improvements in the general health status of the population, an

increase in the amount of education needed to secure employment, a later age at marriage, and a likelihood that a large proportion of all marriages will be dissolved at some time. These factors, and the lessening of social strictures on the sexual activity of women outside of marriage, ensure that a large proportion of the population is single and sexually active.

Furthermore, most of the reasons women themselves give for having an abortion once they are pregnant do not seem readily susceptible to government influence or intervention. Women who must support themselves or their families feel that they have little choice in the matter except to go on public assistance—an option not usually viewed as desirable for raising a family, either by the recipients of such assistance themselves or by society as a whole. For most Americans, education is the key to future employment and self-sufficiency, and its interruption or abandonment is a critical factor in determining the path one's entire life will take. The rate of out-of-wedlock births (not only among teenagers, but also among older age-groups) continues to rise, and relatively few women who choose to continue their pregnancy to term also choose to relinquish their baby for adoption. Most women want to give birth and raise a child in a two-parent, stable family, and will postpone childbearing (if need be, by abortion) to do so. Government can do little to make troubled marriages whole, to keep loving relationships everlasting or to grant instant maturity to young women who believe themselves too immature to bear or raise a child.

If restrictions on access to abortion appear overly intrusive, injurious to the fabric of society or harmful to women, can anything be done to meet the concern of many Americans that the number of abortions be reduced?

Short of a reduction in sexual activity, which would reverse a trend nearly a century long, better, more effective use of contraceptives would lessen the need for, and recourse to, abortion. It is clear that contraceptive use is less universal and less effective in the United States than in many other developed nations. Not only are American couples more likely to depend on the relatively less effective methods, but their use of them is often sporadic. Most other developed countries make contraceptive care generally available to all women at little or no charge through their national health insurance programs. In contrast, in the United States, the cost of effective contraceptive drugs such as the pill is substantial, and subsidized services are by no means always available. In fact, the funding of the major publicly supported family planning program, Title X of the Public Health Service Act, has dropped precipitously in recent years. In addition, family planning services are frequently provided in less convenient and less familiar settings in the United States than in other countries that have lower unintended pregnancy and abortion rates.

Information about contraception and sexuality is, generally, more widely available in other developed nations through public information, media and schools than it is in the United States. Although sex education classes are now the norm in secondary schools in this country, teachers complain that what is offered is "too little, too late" and that they receive little support from parents, their community or the school system in which they teach.[213]

There is abundant evidence that American women and men are dissatisfied with or fearful of existing contraceptive methods. In fact, they have a narrower range of available contraceptive methods than their counterparts in other developed countries and, for that matter, those in many of the less developed countries. Further, very little research is being conducted in the United States to develop new methods of contraception because of a decline in public and private investment in contraceptive research and development, as well as the opposition of many antiabortion activists who are anticontraception as well. Manufacturers' desire to avoid both controversy and legal liability has even made it difficult in the United States to market drugs that have already been developed and are of proven safety and effectiveness.[214]

Although the incidence of unplanned, unwanted pregnancy could be reduced, over time, by concerted public and private efforts, it cannot be eliminated altogether, given the shortcomings of current contraceptive methods, the all-too-human failings of their users and the inescapable fact that some women's life situations may change drastically during pregnancy. Therefore, the issue of the safety of abortion—one of the most common surgical procedures in the United States—is bound to remain a matter of public concern. Although legal abortion, under current circumstances, is extremely safe, it could be made even safer. The prohibition of federally funded research to seek new, less intrusive methods of abortion is hard to justify on scientific or humane grounds. The increased risks that accompany delayed abortion could be reduced by the introduction into the United States of the drug RU 486 (developed in France) or of similar compounds that act before or just after a pregnancy has been established. Educational programs to enable women and girls to recognize the symptoms of pregnancy and the wide availability of free or low cost pregnancy testing could lead to earlier and safer abortion or, alternatively, to earlier entry into prenatal care for women who decide to carry their pregnancy to term. Finally, removing restrictions on access to abortion services for teenagers and restoring Medicaid funding for poor women would allow women to seek and obtain care without the delays—and the attendant health risks—they now face.

If 1973 was a major turning point in the history of reproductive rights in the United States, 1989 and the early 1990s have presented another. The directions of the future of abortion in the United States will emerge from a nationwide debate. Will abortion remain legal and safe? Will it be available to all women without discrimination based on geography, income and age? And will we, as a society, undertake the large-scale and multidimensional efforts needed to deal with the problem that is the root of the abortion dilemma—unintended pregnancy?

## References


1. C. Tietze and S. K. Henshaw, *Induced Abortion: A World Review, 1986*, The Alan Guttmacher Institute (AGI), New York, 1986.

2. J. C. Mohr, *Abortion in America*, Oxford University Press, New York, 1978.

3. AGI, "Abortion in the U.S.: Two Centuries of Experience," *Issues in Brief*, Vol. 2, No. 4, Washington, D.C., Jan. 1982.

4. Center for Disease Control (CDC), *Abortion Surveillance, Annual Summary 1973*, May 1975, p. 9.

5. New York State Department of Health, *Report of Selected Characteristics of Induced Abortions Recorded in New York State*, Jan. 1974, Table 6; ——, *Report of Selected Characteristics of Induced Abortions Recorded in New York State*, Albany, Aug. 1974, Table 6; ——, *Report of Selected Characteristics of Induced Abortions Recorded in New York State*, Albany, Apr. 1971, Table 5; and New York City Department of Health, "New York City Health Department Study Indicates Nearly Half a Million Abortions to City Residents Since 1970 Legalization," press release, Aug. 4, 1977.

6. Ibid.

7. J. Pakter, F. Nelson and M. Svigir, "Legal Abortion: A Half-Decade of Experience," *Family Planning Perspectives*, 7:248, 1975; and R.B. Gold, calculations from unpublished special tabulations by the Bureau of Maternity Services and Family Planning, New York City Department of Health, New York, 1981.

8. C. Tietze and S.K. Henshaw, 1986, op. cit. (see reference 1), pp. 29–42.

9. J. R. Abernathy, B. G. Greenberg and D. G. Horvitz, "Estimates of Induced Abortion in Urban North Carolina," *Demography*, 7:19, 1970.

10. S. Polgar and E. S. Fried, "The Bad Old Days: Clandestine Abortions Among the Poor in New York City Before Liberalization of the Abortion Law," *Family Planning Perspectives*, 8:125, 1976.

11. C. Tyler, CDC, statement before the Subcommittee on Constitutional Amendments of the Committee on the Judiciary, U.S. Senate, Apr. 25, 1974, p. 129.

12. National Center for Health Statistics (NCHS), *Vital Statistics of the United States, 1965: Vol. II—Mortality, Part A*, U.S. Government Printing Office (GPO), Washington, D.C., 1967.

13. W. Cates and R.W. Rochat, "Illegal Abortions in the United States: 1972–1974," *Family Planning Perspectives*, 8:86, 1976.

14. D. D. Swartz and M. K. Paranjpe, "Abortion Services in a Municipal Hospital," *Bulletin of the New York Academy of Medicine*, 47:846, 1971.

15. Institute of Medicine, *Legalized Abortion and the Public Health*, National Academy of Sciences, Washington, D.C., May 1975, p. 65.

16. P. N. Seward, C. Ballard and A. Ulene, "The Effect of Legal Abortion on the Rate of Septic Abortion at a Large County Hospital," *American Journal of Obstetrics and Gynecology*, 115:335, 1973.

17. Buck v. Bell, 274 U.S. 200 (1927).

18. 381 U.S. 479 (1965).

19. 405 U.S. 438 (1972).

20. 410 U.S. 113 (1973); and 410 U.S. 179 (1973).

21. 443 U.S. 622 (1979).

22. AGI, *State Legislative Record, 1973–1989*, Washington, D.C., 1974–1990.

23. 448 U.S. 297 (1980).

24. AGI, "Analysis of 1988 State Laws and Trends," *Washington Memo*, No. W-2, Washington, D.C., Jan. 12, 1989.

25. Webster v. Reproductive Health Services, 57 U.S.L.W., No. 88-605, July 3, 1989.

26. Institute of Medicine, 1975, op. cit. (see reference 15), p. 8.

27. C. E. Koop, Surgeon General of the United States, letter to President Ronald Reagan, Jan. 9, 1989.

28. Hearings before the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, U.S. House of Representatives, Mar. 16, 1989, p. 241.

29. J. D. Forrest, "Unintended Pregnancy Among American Women," *Family Planning Perspectives*, 19:76, 1987.

30. NCHS, "Advance Report of Final Natality Statistics, 1987," *Monthly Vital Statistics Report*, Vol. 38, No. 3, Supplement, June 29, 1989; J. D. Forrest, "Unintended Pregnancy Among American Women," *Family Planning Perspectives*, 19:76, 1987; S. K. Henshaw, J. D. Forrest and J. Van Vort, "Abortion Services in the United States, 1984 and 1985," *Family Planning Perspectives*, 19:63, 1987; and estimations of miscarriages from model developed by C. Tietze and J. Bongaarts, The Population Council (i.e., 10 percent of abortions plus 20 percent of births).

31. Ibid.

32. J. D. Forrest, "Contraceptive Needs Through Stages of Women's Reproductive Lives," *Contemporary Ob/Gyn*, 12:12, 1988.

33. J. D. Forrest and R. R. Fordyce, "U.S. Women's Contraceptive Attitudes and Practice: How Have They Changed in the 1980s?" *Family Planning Perspectives*, 20:112, 1988; J. D. Forrest, unpublished tabulations of data from the 1982 National Survey of Family Growth; and S. K. Henshaw and J. Silverman, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," *Family Planning Perspectives*, 20:158, 1988.

34. S. K. Henshaw and J. Silverman, 1988, op. cit. (see reference 33).

35. Ibid.

36. Ibid.

37. Ibid.

38. Ibid.

39. Ibid.

40. Ibid.

41. Ibid.

42. Ibid.

43. Ibid.

44. Ibid.

45. Ibid.

46. A. Torres and J. D. Forrest, "Why Do Women Have Abortions?" *Family Planning Perspectives*, 20:169, 1988.

47. Ibid.

48. Ibid.

49. Ibid.

50. S. K. Henshaw, J. D. Forrest and J. Van Vort, op. cit. (see reference 30), 1987.

51. Ibid.

52. Ibid.

53. Ibid.

54. Ibid.

55. Calculated from S. K. Henshaw and J. Van Vort, eds., *Abortion Services in the United States, Each State and Metropolitan Area, 1984–1985*, AGI, New York, 1988, p. 90, with estimates for the years 1986–1988.

56. J. D. Forrest, 1987, op. cit. (see reference 29).

57. S. K. Henshaw and J. Van Vort, 1988, op. cit. (see reference 55), p. 91, updated for 1985 from CDC and AGI data.

58. S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

59. S. K. Henshaw and J. Van Vort, eds., 1988, op. cit. (see reference 55), updated for 1985 from CDC and AGI data.

60. S. K. Henshaw, "Characteristics of U.S. Women Having Abortions, 1982–1983," *Family Planning Perspectives*, 19:5, 1987.

61. CDC, *Abortion Surveillance, Annual Summary, 1970*, Atlanta, 1971; ——*Abortion Surveillance, Annual Summary, 1971*, Atlanta, 1972; ——, *Abortion Surveillance, Annual Summary, 1972*, Atlanta, 1974; and S. K. Henshaw and J. VanVort, 1986, op. cit. (see reference 55), updated for 1985 from CDC and AGI data.

62. C. Tietze and S. K. Henshaw, 1986, op. cit. (see reference 1), pp. 88–91.

63. National Abortion Federation (NAF), "What is Abortion?" fact sheet, May 1986; and K.L. Moore, *The Developing Human: Clinically Oriented Embryology*, third ed., W. B. Saunders, Philadelphia, 1982, p. 95.

64. H. W. Lawson et al., "Abortion Surveillance, 1984–1985," CDC Surveillance Summaries, *Morbidity and Mortality Weekly Report*, Vol. 38, No. SS–2, Sept. 1989, p. 11.

65. K. L. Moore, 1982, op. cit. (see reference 63), p. 95.

66. H. W. Lawson et al., 1989, op. cit. (see reference 64).

67. S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

68. Ibid.

69. Ibid., updated for 1985 from CDC and AGI data.

70. S. K. Henshaw, unpublished tabulations of AGI nationwide survey of 9,480 patients, 1987.

71. S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

72. Ibid.

73. S. K. Henshaw, "Freestanding Abortion Clinics: Services, Structure, Fees," *Family Planning Perspectives*, 14:255, 1982.

74. R. B. Gold, unpublished tabulations of data from the NAF Membership Directory, Washington, D.C., 1989.

75. NCHS, 1967, op. cit. (see reference 12).

76. Ibid.

77. H. W. Lawson et al., 1989, op. cit. (see reference 64).

78. W. Cates and R. W. Rochat, 1976, op. cit. (see reference 13); and H. W. Lawson et al., Sept. 1989, op. cit. (see reference 64).

79. N. Binken, J. Gold and W. Cates, "Illegal Abortion Deaths in the United States: Why Are They Still Occurring?" *Family Planning Perspectives*, 14:163, 1982.

80. C. Tietze and S.K. Henshaw, 1986, op. cit. (see reference 1), updated to 1985.

81. H. W. Lawson et al., 1989, op. cit. (see reference 64).

82. Ibid.; and NCHS, *Vital Statistics of the United States, 1985: Vol. II—Mortality, Part A*, GPO, Washington, D.C., 1988.

83. Ibid.; S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30); and NCHS, "Advance Report of Final Natality Statistics, 1987," *Monthly Vital Statistics Report*, Vol. 38, No. 3, 1989.

84. A. H. Rudolph and E. U. Price, "Penicillin — Reactions Among Patients in Venereal Disease Clinics: A National Survey," *Journal of the American Medical Association*, 223:499, 1973.

85. S. K. Henshaw, calculations from special tabulations of data from CDC; and S. K. Henshaw and J. Van Vort, 1988, op. cit. (see reference 55).

**86.** S. K. Henshaw, special tabulations of data from CDC.

**87.** D. A. Grimes, "Second-Trimester Abortions in the United States," *Family Planning Perspectives*, **16:**260, 1984.

**88.** H. B. Peterson et al., "Comparative Risk of Death from Induced Abortion at Less Than or Equal to 12 Weeks' Gestation Performed with Local Versus General Anesthesia," *American Journal of Obstetrics and Gynecology*, **141:**763, 1981.

**89.** D. A. Grimes, W. Cates and C. W. Tyler, "Comparative Risk of Death From Legally Induced Abortion in Hospitals and Nonhospital Facilities," *Obstetrics and Gynecology*, **51:**323, 1978; W. Cates and D. A. Grimes, "Deaths from Second Trimester Abortion by Dilation and Evacuation: Causes, Prevention and Facilities," *Obstetrics and Gynecology*, **58:**401, 1981; and D. A. Grimes, W. Cates and R. M. Selik, "Abortion Facilities and the Risk of Death," *Family Planning Perspectives*, **13:**30, 1981.

**90.** H. K. Atrash et al., "Legal Abortion Mortality in the United States: 1972–1982," *American Journal of Obstetrics and Gynecology*, **156:**605, 1987; and S. K. Henshaw, calculations from special tabulations of data from CDC.

**91.** Ibid.

**92.** C. Tietze and S. K. Henshaw, 1986, op. cit. (see reference 1).

**93.** Ibid.

**94.** NAF, Abortion Practice Advancement program, *Summary of Annual Statistics*, Washington D.C., 1988. Statistics report complications among 68,828 patients with follow-up in 1988.

**95.** C. Tietze and S. K. Henshaw, 1986, op. cit. (see reference 1).

**96.** Ibid.

**97.** H. T. MacKay, K. F. Schulz and D. A. Grimes, "Safety of Local Versus General Anesthesia for Second-Trimester Dilatation and Evacuation Abortion," *Obstetrics and Gynecology*, **66:**661, 1985.

**98.** W. Cates, "Legal Abortion: The Public Health Record," *Science*, **215:**1,586, 1982.

**99.** W. Cates, K. F. Schulz and D. A. Grimes, "The Risk Associated with Teenage Abortion," *New England Journal of Medicine*, **309:**621, 1983.

**100.** H. P. David, Transnational Family Research Institute, statement (on behalf of the American Public Health Association), before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, U.S. House of Representatives, Mar. 16, 1989.

**101.** W. Franz, National Right to Life Committee, statement (on behalf of the Association for Interdisciplinary Research in Values and Social Change), before the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, U.S. House of Representatives, Mar. 16, 1989.

**102.** *Congressional Record*, Mar. 21, 1989, p. E908.

**103.** N. Adler, University of California at San Francisco, statement (on behalf of the American Psychological Association), before the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, U.S. House of Representatives, Mar. 16, 1989, p. 138.

**104.** Ibid.; J. C. Kleinman, NCHS, memorandum to C. E. Koop "Comments on 'A Report on the Psychological Aftermath of Abortion,'" Oct. 30, 1987.

**105.** H.P. David, 1989, op. cit. (see reference 10 p.101).

**106.** L. S. Zabin, M. B. Hirsh and M. R. Emerson, "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy," *Family Planning Perspectives*, **21:**248, 1989.

**107.** J. Gentry, American Psychological Association, personal communication, Oct. 19, 1989.

**108.** N. Adler, 1989, op. cit. (see reference 103), p. 130.

**109.** Ibid., pp. 138–139.

**110.** *Congressional Record*, 1989, op. cit. (see reference 102).

**111.** N. Adler, 198_, op. cit. (see reference 103) p. 140.

**112.** AGI, *Safe and Legal: 10 Years' Experience With Legal Abortion in New York State*, New York, 1980, p.22.

**113.** C. Tietze, "The Public Health Effects of Legal Abortion in the United States," *Family Planning Perspectives*, **16:**26, 1984.

**114.** "Legal Abortion, Family Planning Services Largest Factors in Reducing U.S. Neonatal Mortality Rate," *Family Planning Perspectives*, **13:**84, 1981; M. Grossman and S. Jacobowitz, "Determinants of Variations in Infant Mortality Rates Among Counties in the United States: The Roles of Social Policies and Progr. ms," paper presented at the World Congress on Health Economics, Leiden, The Netherlands, Sept. 8–11, 1980.

**115.** Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, Washington, D.C., 1985, p. 126.

**116.** A. Luthy et al., "Prenatal Genetic Diagnosis and Elective Abortion in Women Over 35: Utilization and Relative Impact on the Birth Prevalence of Down's Syndrome in Washington State," *American Journal of Medical Genetics*, **7:**375, 1980; and R. Smith et al., "The Effect of Induced Abortion on the Incidence of Down's Syndrome," *Family Planning Perspectives*, **12:**201, 1980.

**117.** S. K. Henshaw and J. Silverman, 1988, op. cit. (see reference 33).

**118.** C. J. R. Hogue, W. Cates and C. Tietze, "The Effects of Induced Abortion on Subsequent Reproduction," *Epidemiologic Reviews*, **4:**66, 1982.

**119.** Ibid.

120. Webster v. Reproductive Health Services, 1989, op. cit. (see reference 25).

121. Ibid.

122. Webster v. Reproductive Health Services, 1989, op. cit. (see reference 25).

123. AGI, 1974–1988, op. cit (see reference 22).

124. Ibid.

125. Ibid.

126. Ibid.

127. AGI, "U.S. Supreme Court Guts *Roe*, Invites State Abortion Restriction," *Washington Memo*, No. W-12, July 11, 1989, Washington, D.C.; J. Hodgson et al. v. State of Minnesota et al., No. 88-1125; and Ohio v. Akron Center for Reproductive Health, No. 88-805.

128. Louis Harris and Associates, "Public Rejects High Court Overturn of Roe v. Wade by 57–40 Percent," poll, Jan. 29, 1989; E. J. Dionne, "Poll Finds Ambivalence on Abortion Persists in U.S.," *New York Times*, Aug. 3, 1989; and D. Balz, "Poll Finds Majority in U.S. Back Abortion Rights," *Washington Post*, Oct. 7, 1989.

129. Ibid.

130. Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

131. E. Plutzer and B. Ryan, "Notifying Husband About an Abortion: An Empirical Look at Constitutional and Policy Dilemmas," *Sociology and Social Research*, **71**:183, 1987.

132. J. D. Forrest and A. Torres, "Reasons Women Choose Abortion and Factors in Timing of Abortions Past 15 Weeks LMP," presentation at the American Public Health Association annual meeting, Boston, Nov. 1988.

133. S.K. Henshaw and J. Silverman, 1988, op. cit. (see reference 33).

134. Illinois House Bill Number 1790, introduced Apr. 10, 1989.

135. L. Richardson, Cellmark Diagnostics, personal communication, Aug. 11, 1989.

136. A. Torres, J. D. Forrest and S. Eisman, "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," *Family Planning Perspectives*, **12**:284, 1980.

137. Office for Family Planning, Bureau of Community Health Services, U.S. Department of Health, Education, and Welfare, *Family Planning, Contraception, Voluntary Sterilization and Abortion: An Analysis of Laws and Policies in the United States, Each State and Jurisdiction*, 1978, Washington, D.C., p. 101.

138. U.S. Bureau of the Census, "Marital Status and Living Arrangements: March 1988," *Current Population Reports*, Series P-20, No. 433, 1989, Table 4.

139. F. F. Furstenberg et al., "The Life Course of Children of Divorce: Marital Disruption and Parental Contact," *American Sociological Review*, **48**:656, 1983.

140. American Civil Liberties Union/Reproductive Freedom Project, *Parental Notification Laws, Their Catastrophic Impact on Teenagers' Right to Abortion*, New York, 1986, p. 15.

141. Ohio Revised Code, § 2919.12.

142. V. G. Cartoof and L. V. Klerman, "Parental Consent for Abortion: Impact of the Massachusetts Law," *American Journal of Public Health*, **76**:397, 1986.

143. S. Yates and A. J. Pliner, "Judging Maturity in the Courts: The Massachusetts Consent Statute," *American Journal of Public Health*, **78**:646, 1988.

144. The American Civil Liberties Union/Reproductive Freedom Project, 1986, op. cit. (see reference 140), p.15.

145. Hodgson et al. v. State of Minnesota et al., op. cit. (see reference 127), calculated from Plaintiff's exhibit 122.

146. Maine Revised Statutes, Annotated, § 1597-A.

147. A. Torres and J. D. Forrest, 1988, op. cit. (see reference 46).

148. M. Lupfer and B. G. Silber, "How Patients View Mandatory Waiting Periods for Abortion," *Family Planning Perspectives*, **13**:75, 1981.

149. Ibid.

150. City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983).

151. S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

152. S. K. Henshaw and J. Silverman, 1988, op. cit. (see reference 33).

153. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*, Vol. 1, Washington, D.C., 1982, p. 18.

154. Ibid., p. 2.

155. Ibid.

156. American Medical Association (AMA), *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association–1986*, Chicago, 1986, pp. 31–32.

157. American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services*, Washington, D.C., 1985, p. 57.

158. NAF, *Standards for Abortion Care*, 1986, Washington, D.C., p. 7a.

159. City of Akron v. Akron Center for Reproductive Health, 1983, op. cit. (see reference 121).

160. S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

161. D. A. Grimes, W. Cates and C.W. Tyler, 1978, op. cit. (see reference 89); W. Cates and D.A. Grimes,

1981, op. cit. (see reference 89); D.A. Grimes, W. Cates and R. M. Selik, 1981, op. cit. (see reference 89).

**162.** S. K. Henshaw, 1982, op. cit. (see reference 73).

**163.** NAF, 1986, op. cit. (see reference 158).

**164.** Planned Parenthood Federation of America (PPFA), "Abortion Services in Planned Parenthood Affiliates," *Abortion Standards and Guidelines*, New York, 1977.

**165.** Ragsdale v. Turnock, 625 F. Supp. 1212 (N.D Ill. 1985), aff'd, 841 F2d 1358 (7th Cir. 1988).

**166.** NAF and PPFA, Amicus Brief in Turnock v. Ragsdale, October Term of the Supreme Court, 1989, p. 25.

**167.** Ibid., pp. 18–19.

**168.** AGI, 1974–1988, op. cit. (see reference 22).

**169.** W. Cates and D.A. Grimes, 1981, op. cit. (see reference 89).

**170.** ACOG, *Standards for Obstetric-Gynecologic Services*, seventh ed., Washington, D.C., 1989.

**171.** S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

**172.** S. K. Henshaw and J. Van Vort, 1988, op. cit. (see reference 55), table 7.

**173.** M. T. Orr and J. D. Forrest, "The Availability of Reproductive Health Services from U.S. Private Physicians," *Family Planning Perspectives*, **17**:63, 1985.

**174.** S. K. Henshaw, calculations from S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

**175.** ——, unpublished tabulation of data from nationwide AGI survey of abortion patients, 1985.

**176.** J. D. Forrest, unpublished tabulations of data from nationwide AGI survey of private physicians, 1983.

**177.** *Los Angeles Times*, poll, Mar. 1989.

**178.** Social Security Act, § 1901.

**179.** S. Singh, R. B. Gold and A. Kenney, *The Financing of Maternity Care in the United States*, AGI, New York, 1987.

**180.** R. B. Gold and S. Guardado, "Public Funding of Family Planning, Sterilization and Abortion Services, 1987," *Family Planning Perspectives*, **20**:228, 1988.

**181.** AGI, 1989, op. cit. (see reference 24), p. 5.

**182.** I. Hill, National Governors' Association, memorandum, Aug. 17, 1989.

**183.** J. T. Trussell, "The Impact of Restricting Medicaid Financing for Abortion," *Family Planning Perspectives*, **12**:120, 1980.

**184.** A. Torres et al., "Public Benefits and Costs of Government Funding for Abortion," *Family Planning Perspectives*, **18**:111, 1986.

**185.** Ibid.

**186.** S. K. Henshaw and L. S. Wallisch, "The Medicaid Cutoff and Abortion Services for the Poor," *Family Planning Perspectives*, **16**:170, 1984.

**187.** Ibid.

**188.** Ibid.

**189.** Missouri Revised Statute, § 188.215 (1988).

**190.** S. K. Henshaw, 1985, op. cit. (see reference 175).

**191.** J. D. Forrest, 1983, op. cit. (see reference 175).

**192.** S. K. Henshaw, 1987, op. cit. (see reference 70).

**193.** United Press International, "Missouri Abortion Restrictions Send Woman with Deformed Fetus Across State Line," *New York Post*, July 24, 1989.

**194.** American Hospital Association, *Hospital Statistics, 1987*, Chicago, 1987.

**195.** P. D. Darney et al., "Abortion Training in U.S. Obstetrics and Gynecology Residency Programs," *Family Planning Perspectives*, **19**:159, 1987.

**196.** AGI, 1974–1988, op. cit. (see reference 22).

**197.** President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982, op. cit. (see reference 153), pp. 2–3.

**198.** Ibid., pp. 2–6.

**199.** AMA, 1986, op. cit. (see reference 156); and ACOG, 1985, op. cit. (see reference 156).

**200.** National Opinion Research Center, survey, Chicago, Feb.–Mar. 1989.

**201.** S. K. Henshaw and J. Van Vort, eds, 1988, op. cit. (see reference 55).

**202.** Ibid.

**203.** A. Torres and J. D Forrest, 1988, op. cit. (see reference 46).

**204.** S. K. Henshaw, J. D. Forrest and J. Van Vort, 1987, op. cit. (see reference 30).

**205.** A. Torres and J. D Forrest, 1988, op. cit. (see reference 46).

**206.** National Opinion Research Center 1989, op. cit., (see reference 200).

**207.** A Torres and J. D. Forrest, 1988, op. cit. (see reference 46).

**208.** J. D. Forrest and R. R. Fordyce, 1988, op. cit. (see reference 33).

**209.** President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, October 1982, op. cit. (see reference 153), p. 57, and D.C. Wertz and J.C. Fletcher, "Fatal Knowledge? Prenatal Diagnosis and Sex Selection," *Hastings Center Report*, Vol. 19, No. 3, May/June 1989, p. 21.

**210.** President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "Screening and Counseling for Genetic Conditions: The Ethical, Social and Legal Implications of Genetic Screening, Counseling and Education Programs," Washington, D.C., Feb. 1983.

**211.** D. C. Wertz and J. C. Fletcher, 1989, op. cit. (see reference 209), p. 21.

**212.** E. F. Jones et al., "Unintended Pregnancy, Contraceptive Practice and Family Planning Services in Developed Countries," *Family Planning Perspectives*, **20**:53, 1988.

**213.** A. M. Kenney, S. Guardado and L. Brown, "Sex Education and AIDS Education in the Schools: What States and Large School Districts Are Doing," *Family Planning Perspectives*, **21**:56, 1989; and J. D. Forrest and J. Silverman, "What Public School Teachers Teach About Preventing Pregnancy, AIDS and Sexually Transmitted Diseases," *Family Planning Perspectives*, **21**:65, 1989.

**214.** R. Lincoln and L. Kaeser, "Whatever Happened to the Contraceptive Revolution?" *Family Planning Perspectives*, **20**:20, 1988.

## Notes to Figures

**Figure 1.** Number of women obtaining an abortion in New York State, by their state of residence (including the District of Columbia): Maine, 3,429; New Hampshire, 3,083; Vermont, 1,834; Massachusetts, 28,841; Connecticut, 14,618; Rhode Island, 4,030; **Total: 55,835.**

New Jersey, 49,979; Pennsylvania, 29,510; Maryland, 1,969; Delaware, 1,141; District of Columbia, 640; **Total: 83,239.**

Virginia, 4,655; West Virginia, 1,765; Kentucky, 5,414; Tennessee, 6,238; North Carolina, 3,252; South Carolina, 3,236; Mississippi, 1,522; Alabama, 1,941; Georgia, 8,160; Florida, 18,995; **Total: 55,178.**

Texas, 3,999; Oklahoma, 1,198; Arkansas, 1,101; Louisiana, 2,537; **Total: 8,835.**

California, 454; Nevada, 85; Arizona, 155; New Mexico, 126; Colorado, 1,084; Utah, 81; **Total: 1,985.**

Washington, 131; Oregon, 36; Idaho, 54; Montana, 600; Wyoming, 152; **Total: 973.**

North Dakota, 404; South Dakota, 247; Nebraska, 1,817; Kansas, 609; Minnesota, 5,004; Iowa, 3,667; Missouri, 6,060; Wisconsin, 4,801; **Total: 22,609.**

Illinois, 29,986; Michigan, 31,148; Indiana, 11,332; Ohio, 33,038; **Total: 105,504.**

Alaska, 55; Hawaii, 24; **Total: 79.**

**Figure 4.** Average age of women: menarche, 12.6; first intercourse, 17.9; first marriage, 24.2; first birth, 25.5; last wanted birth, 29.1; menopause, 49.8.

**Figure 9.** Annual number of legal abortions: 1969, 22,670; 1970, 193,491; 1971, 485,816; 1972, 586,760; 1973, 744,600; 1974, 898,600; 1975, 1,034,200; 1976, 1,179,300; 1977, 1,316,700; 1978, 1,409,600; 1979, 1,497,700; 1980, 1,553,900; 1981, 1,577,300; 1982, 1,573,900; 1983, 1,575,000; 1984, 1,577,200; 1985, 1,588,600.

**Figure 10.** Percentage of abortions performed at ≤8 weeks' gestation, by year: 1970, 19.5; 1971, 33.9; 1972, 34.0; 1973, 38.2; 1974, 44.5; 1975, 46.5; 1976, 47.4; 1977, 50.0; 1978, 50.2; 1979, 50.0; 1980, 51.5; 1981, 51.4; 1982, 51.2; 1983, 50.3; 1984, 51.6; 1985, 51.5.

**Figure 13.** Deaths from abortion (excluding spontaneous abortions), by year: 1965, 201; 1966, 158; 1967, 131; 1968, 108; 1969, 117; 1970, 136; 1971, 109; 1972, 65; 1973, 47; 1974, 33; 1975, 34; 1976, 14; 1977, 21; 1978, 16; 1979, 18; 1980, 11; 1981, 8; 1982, 12; 1983, 11; 1984, 11; 1985, 7.

**Figure 15.** Deaths per 100,000 abortions, by duration of pregnancy: ≤8 weeks, 0.2; 9–10 weeks, 0.3; 11–12 weeks, 0.6; 13–15 weeks, 1.8; 16–20 weeks, 3.7; ≥21 weeks, 12.7.

**Figure 16b.** Percentage of abortions with complications, by duration of pregnancy: ≤6 weeks, 0.42; 7–8 weeks, 0.16; 9–10 weeks, 0.13; 11–12 weeks, 0.31; 13–14 weeks, 0.55; 15–16 weeks, 1.34; 17–20 weeks, 1.87; ≥21 weeks, 1.52. Percentages are based on patients with follow-up.

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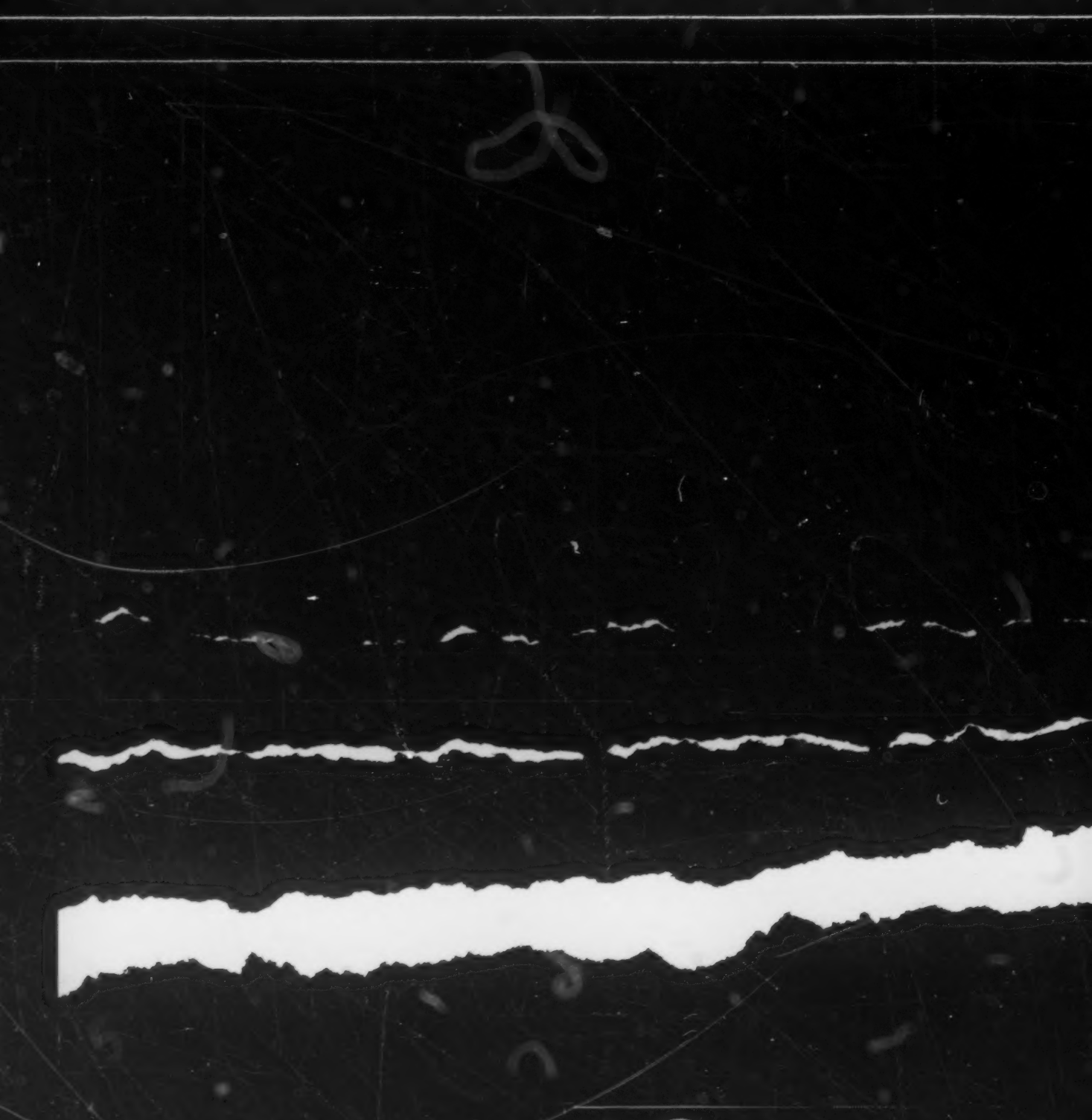

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